An act to amend Sections 14005.7, 14005.9, 14005.11, 14005.12, 14005.13, 14005.21, 14005.26, 14005.32, 14005.41, 14005.42, 14006.4, 14009, 14011, 14011.65, 14011.8, 14015, 14015.12, 14016, 14019.4, 14054, 14110.8, 14132, 14132.56, 14132.95, 14132.99, 14148.5, and 14154.5 of, and to add Sections 14005.95, 14051.7, and 14051.8 to, the Welfare and Institutions Code, relating to Medi-Cal.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14005.7 of the Welfare and Institutions Code is amended to read:

14005.7. (a) Medically needy persons and medically needy family persons are entitled to health care services under Section 14005 providing all eligibility criteria established pursuant to this chapter are met.

(b) Except as otherwise provided in this chapter or in Title XIX of the federal Social Security Act, no medically needy family person, medically needy person or state-only Medi-Cal persons shall be entitled to receive health care services pursuant to Section 14005 during any month in which ~~his or her share of cost~~ their spend down of excess income has not been met.

(c) In the case of a medically needy person, monthly income, as determined, defined, counted, and valued, in accordance with Title XIX of the federal Social Security Act, in excess of the amount required for maintenance established pursuant to Section 14005.12, exclusive of any amounts considered exempt as income under Chapter 3 (commencing with Section 12000), less amounts paid for Medicare and other health insurance premiums shall be the ~~share of cost~~ spend down of excess income to be met under Section 14005.9.

(d) In the case of a medically needy family person or state-only Medi-Cal person, monthly income, as determined, defined, counted, and valued, in accordance with Title XIX of the federal Social Security Act, in excess of the amount required for maintenance established pursuant to Section 14005.12, exclusive of any amounts considered exempt as income under Chapter 2 (commencing with Section 11200), less amounts paid for Medicare and other health insurance premiums shall be the ~~share of cost~~ spend down of excess income to be met under Section 14005.9.

(e) In determining the income of a medically needy person residing in a licensed community care facility, income shall be determined, defined, counted, and valued, in accordance with Title XIX of the federal Social Security Act, any amount paid to the facility for residential care and support that exceeds the amount needed for maintenance shall be deemed unavailable for the purposes of this chapter.

(f) (1) For purposes of this section the following definitions apply:

(A) "SSI" means the federal Supplemental Security Income program established under Title XVI of the federal Social Security Act.

(B) "MNL" means the income standard of the Medi-Cal medically needy program defined in Section 14005.12.

(C) Board and care "personal care services" or "PCS" deduction means the income disregard that is applied to a resident in a licensed community care facility, in lieu of the board and care deduction specified in subdivision (e) of Section 14005.7, when the PCS deduction is greater than the board and care deduction.

(2) (A) For purposes of this section, the SSI recipient retention amount is the amount by which the SSI maximum payment amount to an individual residing in a licensed community care facility exceeds the maximum amount that the state allows community care facilities to charge a resident who is an SSI recipient.

(B) For purposes of this section, the personal and incidental needs deduction for an individual residing in a licensed community care facility is either of the following:

(i) If the deduction specified in subdivision (e) is applicable to the individual, the amount, not to exceed the amount by which the SSI recipient retention amount exceeds twenty dollars ($20), nor to be less than zero, by which the sum of the amount that the individual pays to ~~his or her~~ their licensed community care facility and the SSI recipient retention amount exceed the sum of the individual's MNL, the individual's board and care deduction, and twenty dollars ($20).

(ii) If the deduction specified in paragraph (1) is applicable to the individual, an amount, not to exceed the amount by which the SSI recipient retention amount exceeds twenty dollars ($20), nor to be less than zero, by which the sum of the amount ~~which~~ that the individual pays to ~~his or her~~ their community care facility and the SSI recipient retention amount exceed the sum of the individual's MNL, the individual's PCS deduction and twenty dollars ($20).

(3) In determining the countable income of a medically needy individual residing in a licensed community care facility, the individual shall have deducted from ~~his or her~~ their income the amount specified in subparagraph (B) of paragraph (2).

(g) No later than one month after the effective date of subparagraph (B) of paragraph (2) of subdivision (f), the department shall submit to the federal medicaid administrator a state plan amendment seeking approval of the income deduction specified in subdivision (f), and of federal financial participation for the costs resulting from that income deduction.

(h) The deduction prescribed by paragraph (3) of subdivision (f) shall be applied no later than the first day of the fourth month after the month in which the department receives approval for the federal financial participation specified in subdivision (g). Until approval for federal financial participation is received by the department, there shall be no deduction under paragraph (3) of subdivision (f).

SEC. 2. Section 14005.9 of the Welfare and Institutions Code is amended to read:

14005.9. (a) ~~Share of cost~~ The spend down amount of excess income necessary to become eligible for Medi-Cal shall be determined on a monthly basis. No person or family shall be required to incur more than one month's ~~share of cost~~ spend down amount of excess income to become eligible for Medi-Cal prior to being certified as specified in Section 14018.

~~(b) For persons in long-term care, any income exempted under Sections 14005.4 and 14005.7 shall be considered in the share-of-cost determination to the extent required by federal law or regulations.~~

~~(c)~~

(b) Once the beneficiary has incurred expenses for Medicare and other health insurance deductibles or coinsurance charges and necessary medical and remedial services that are not subject to payment by a third party and ~~which~~ that equal or exceed ~~his or her share of cost,~~ their spend down of excess income to become eligible for Medi-Cal, the individual is entitled to receive health care services pursuant to Section 14005 if all other applicable conditions of eligibility under this chapter are met.

SEC. 3. Section 14005.11 of the Welfare and Institutions Code is amended to read:

14005.11. (a) To the extent required by federal law for qualified Medicare beneficiaries, the department shall pay the premiums, deductibles, and coinsurance for elderly and disabled persons entitled to benefits under Title XVIII of the federal Social

Security Act, whose income does not exceed the federal poverty level and whose resources do not exceed 200 percent of the Supplemental Security Income program standard.

(b) The department shall, in addition to subdivision (a), pay applicable additional premiums, deductibles, and coinsurance for drug coverage extended to qualified Medicare beneficiaries.

(c) The deductible payments required by subdivision (b) may be covered by providing the same drug coverage as offered to categorically needy recipients, as defined in Section 14050.1.

(d) As specified in this section, it is the intent of the Legislature to assist in the payment of Medicare Part B premiums for qualified low-income Medi-Cal beneficiaries who are ineligible for federal sharing or federal contribution for the payment of those premiums.

(e) For a Medi-Cal beneficiary who has a ~~share of cost~~ spend down of excess income but who is ineligible for the assistance provided pursuant to subdivision (a), or who is ineligible for any other federally funded assistance for the payment of the beneficiary's Medicare Part B premium, the department shall pay for the beneficiary's Medicare Part B premium in the month following each month that the beneficiary's ~~share of cost~~ spend down of excess income has been met.

(f) When a county is informed that an applicant or beneficiary is eligible for Medicare benefits, the county shall determine whether that individual is eligible under the Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiary (SLMB) program, or the Qualifying Individual program and enroll the applicant or beneficiary in the appropriate program.

SEC. 4. Section 14005.12 of the Welfare and Institutions Code, as amended by Section 72 of Chapter 47 of the Statutes of 2022, is amended to read:

14005.12. (a) For the purposes of Sections 14005.4 and 14005.7, the department shall establish the income levels for maintenance need at the lowest levels that reasonably permit medically needy persons to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under Title XIX of the federal Social Security Act. It is the intent of the Legislature that the income levels for maintenance need for medically needy aged, blind, and disabled adults, in particular, shall be based upon amounts that adequately reflect their needs.

(1) Subject to paragraph (2), reductions in the maximum aid payment levels set forth in subdivision (a) of Section 11450 in the 1991–92 fiscal year, and thereafter, shall not result in a reduction in the income levels for maintenance under this section.

(2) (A) The department shall seek any necessary federal authorization for maintaining the income levels for maintenance at the levels in effect June 30, 1991.

(B) If federal authorization is not obtained, medically needy persons shall not be required to pay the difference between the ~~share of cost~~ spend down of excess income as determined based on the payment levels in effect on June 30, 1991, under Section 11450, and the ~~share of cost~~ spend down of excess income as determined based on the payment levels in effect on July 1, 1991, and thereafter.

(3) Any medically needy person who was eligible for benefits under this chapter as categorically needy for the calendar month immediately preceding the effective date of the reductions in the minimum basic standards of adequate care for the Aid to Families with Dependent Children program as set forth in Section 11452.018 made in

the 1995–96 Regular Session of the Legislature shall not be responsible for paying their ~~share of cost~~ spend down of excess income if all of the following apply:

(A) The person had eligibility as categorically needy terminated by the reductions in the minimum basic standards of adequate care.

(B) The person, but for the reductions, would be eligible to continue receiving benefits under this chapter as categorically needy.

(C) The person is ineligible to receive benefits without a ~~share of cost~~ spend down of excess income as a medically needy person pursuant to paragraph (1) or (2).

(b) In the case of a single individual, the amount of the income level for maintenance per month shall be 80 percent of the highest amount that would ordinarily be paid to a family of two persons, without any income or resources, under subdivision (a) of Section 11450, multiplied by the federal financial participation rate.

(c) In the case of a family of two adults, the income level for maintenance per month shall be the highest amount that would ordinarily be paid to a family of three persons without income or resources under subdivision (a) of Section 11450, multiplied by the federal financial participation rate.

(d) For the purposes of Sections 14005.4 and 14005.7, for a person in a medical institution or nursing facility, or for a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization pursuant to Chapter 8.75 (commencing with Section 14591), the amount considered as required for maintenance per month shall be computed in accordance with, and for those purposes required by, Title XIX of the federal Social Security Act, and regulations adopted pursuant thereto. Those amounts shall be computed pursuant to regulations that include providing for the following purposes:

(1) Personal and incidental needs in the amount of not less than thirty-five dollars ($35) per month while a patient. The department may, by regulation, increase this amount as necessitated by increasing costs of personal and incidental needs. A long-term health care facility shall not charge an individual for the laundry services or periodic hair care specified in Section 14110.4.

(2) The upkeep and maintenance of the home.

(3) The support and care of their minor children, or any disabled relative for whose support they have contributed regularly, if there is no community spouse.

(4) If the person is an institutionalized spouse, for the support and care of their community spouse, minor or dependent children, dependent parents, or dependent siblings of either spouse, provided the individuals are residing with the community spouse.

(5) The community spouse monthly income allowance shall be established at the maximum amount permitted in accordance with Section 1924(d)(1)(B) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396r-5(d)(1)(B)).

(6) The family allowance for each family member residing with the community spouse shall be computed in accordance with the formula established in Section 1924(d)(1)(C) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396r-5(d)(1)(C)).

(e) For the purposes of Sections 14005.4 and 14005.7, with regard to a person in a licensed community care facility, the amount considered as required for maintenance per month shall be computed pursuant to regulations adopted by the department that

provide for the support and care of their spouse, minor children, or any disabled relative for whose support they have contributed regularly.

(f) The income levels for maintenance per month, except as specified in subdivisions (b) to (d), inclusive, shall be equal to the highest amounts that would ordinarily be paid to a family of the same size without any income or resources under subdivision (a) of Section 11450, multiplied by the federal financial participation rate.

(g) The "federal financial participation rate," as used in this section, shall mean 133 ⅓ percent, or such other rate set forth in Section 1903 of the federal Social Security Act (42 U.S.C. Sec. 1396(b)), or its successor provisions.

(h) The income levels for maintenance per month shall not be decreased to reflect the presence in the household of persons receiving forms of aid other than Medi-Cal.

(i) When family members maintain separate residences, but eligibility is determined as a single unit under Section 14008, the income levels for maintenance per month shall be established for each household in accordance with subdivisions (b) to (h), inclusive. The total of these levels shall be the level for the single eligibility unit.

(j) The income levels for maintenance per month established pursuant to subdivisions (b) to (i), inclusive, shall be calculated on an annual basis, rounded to the next higher multiple of one hundred dollars ($100), and then prorated.

(k) If the conditions described in paragraph (2) of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the department pursuant to paragraph (3) of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 5. Section 14005.12 of the Welfare and Institutions Code, as added by Section 73 of Chapter 47 of the Statutes of 2022, is amended to read:

14005.12. (a) For the purposes of Sections 14005.4 and 14005.7, the department shall establish the income levels for maintenance need at the lowest levels that reasonably permit medically needy persons to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under Title XIX of the federal Social Security Act. It is the intent of the Legislature that the income levels for maintenance need for medically needy aged, blind, and disabled adults, in particular, shall be based upon amounts that adequately reflect their needs.

(1) Subject to paragraph (2), reductions in the maximum aid payment levels set forth in subdivision (a) of Section 11450 in the 1991–92 fiscal year, and thereafter, shall not result in a reduction in the income levels for maintenance under this section.

(2) (A) The department shall seek any necessary federal authorization for maintaining the income levels for maintenance at the levels in effect June 30, 1991, and, commencing no sooner than January 1, 2025, as described in subdivision (b).

(B) If federal authorization is not obtained, medically needy persons shall not be required to pay the difference between the ~~share of cost~~ spend down of excess income as determined based on the payment levels in effect on June 30, 1991, under Section 11450, and the ~~share of cost~~ spend down of excess income as determined based on the payment levels in effect on July 1, 1991, and thereafter.

(3) Any medically needy person who was eligible for benefits under this chapter as categorically needy for the calendar month immediately preceding the effective date

of the reductions in the minimum basic standards of adequate care for the Aid to Families with Dependent Children program as set forth in Section 11452.018 made in the 1995–96 Regular Session of the Legislature shall not be responsible for paying their ~~share of cost~~ spend down of excess income if all of the following apply:

(A) The person had eligibility as categorically needy terminated by the reductions in the minimum basic standards of adequate care.

(B) The person, but for the reductions, would be eligible to continue receiving benefits under this chapter as categorically needy.

(C) The person is ineligible to receive benefits without a ~~share of cost~~ spend down of excess income as a medically needy person pursuant to paragraph (1) or (2).

(b) (1) Effective no sooner than January 1, 2025, and to the extent the department determines the conditions described in paragraph (2) have been met, the amount of the income level for maintenance per month shall be equal to the income limit for Medi-Cal without a ~~share of cost~~ spend down of excess income for individuals described in Section 1396a(m)(1)(A) of Title 42 of the United States Code, as that income limit is calculated pursuant to paragraph (3) of subdivision (c) of Section 14005.40.

(2) Implementation of this section is contingent on both of the following conditions:

(A) All necessary federal approvals have been obtained by the department.

(B) The Legislature has appropriated funding to implement this section after a determination that ongoing General Fund resources are available to support the ongoing implementation of this section in the 2024–25 fiscal year and subsequent fiscal years.

(3) The department shall issue a declaration certifying the date that all conditions in paragraph (2) have been met. The department shall post the declaration on its internet website and provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(c) For the purposes of Sections 14005.4 and 14005.7, for a person in a medical institution or nursing facility, or for a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization pursuant to Chapter 8.75 (commencing with Section 14591), the amount considered as required for maintenance per month shall be computed in accordance with, and for those purposes required by, Title XIX of the federal Social Security Act, and regulations adopted pursuant thereto. Those amounts shall be computed pursuant to regulations that include providing for the following purposes:

(1) Personal and incidental needs in the amount of not less than thirty-five dollars ($35) per month while a patient. The department may, by regulation, increase this amount as necessitated by increasing costs of personal and incidental needs. A long-term health care facility shall not charge an individual for the laundry services or periodic hair care specified in Section 14110.4.

(2) The upkeep and maintenance of the home.

(3) The support and care of their minor children, or any disabled relative for whose support they have contributed regularly, if there is no community spouse.

(4) If the person is an institutionalized spouse, for the support and care of their community spouse, minor or dependent children, dependent parents, or dependent siblings of either spouse, provided the individuals are residing with the community spouse.

(5) The community spouse monthly income allowance shall be established at the maximum amount permitted in accordance with Section 1924(d)(1)(B) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396r-5(d)(1)(B)).

(6) The family allowance for each family member residing with the community spouse shall be computed in accordance with the formula established in Section 1924(d)(1)(C) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396r-5(d)(1)(C)).

(d) For the purposes of Sections 14005.4 and 14005.7, with regard to a person in a licensed community care facility, the amount considered as required for maintenance per month shall be computed pursuant to regulations adopted by the department that provide for the support and care of their spouse, minor children, or any disabled relative for whose support they have contributed regularly.

(e) The income levels for maintenance per month shall not be decreased to reflect the presence in the household of persons receiving forms of aid other than Medi-Cal.

(f) When family members maintain separate residences, but eligibility is determined as a single unit under Section 14008, the income levels for maintenance per month shall be established for each household in accordance with subdivisions (b) to (e), inclusive. The total of these levels shall be the level for the single eligibility unit.

(g) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-county letters, provider bulletins or notices, policy letters, or other similar instructions, without taking any further regulatory action. Within two calendar years of implementing subdivision (d) of Section 14005.12, the department shall adopt, amend, or repeal any necessary regulations.

(h) This section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (3) of subdivision (b), whichever is later.

SEC. 6. Section 14005.13 of the Welfare and Institutions Code, as amended by Section 74 of Chapter 47 of the Statutes of 2022, is amended to read:

14005.13. (a) Notwithstanding Section 14005.12, when an individual residing in a long-term care facility would incur a ~~share of cost~~ long-term care patient liability for services under this chapter due to income that exceeds that allowed for the incidental and personal needs of the individual, a specified portion of the individual's earned income from therapeutic wages shall be exempt. Therapeutic wages are wages earned by the individual under all of the following conditions:

(1) A physician who does not have a financial interest in the long-term care facility in which the individual resides, and who is in charge of the individual's case, prescribes work as therapy for the individual.

(2) The individual must be employed within the same long-term care facility where they reside.

(3) The individual's employment does not displace any existing employees.

(4) The individual has resided in a long-term care facility for a continuous period commencing at least five years prior to the date of the addition of this section as originally adopted during the 1983–84 Regular Session.

(b) The amount of earned income from therapeutic wages that shall be exempt shall be the lesser of 70 percent of the gross therapeutic wages or 70 percent of the

maintenance level for a noninstitutionalized person or family of corresponding size as described in subdivision (b), (c), or (e) of Section 14005.12.

(c) The provisions of this section shall be given retroactive effect for the period commencing June 1, 1983.

(d) This section shall not become operative unless and until the necessary waivers are obtained from the United States Department of Health and Human Services.

(e) The director shall adopt regulations implementing this section as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the purposes of the Administrative Procedure Act, the adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted by the department in order to implement this section shall not be subject to the review and approval of the Office of Administrative Law. These regulations shall become effective immediately upon filing with the Secretary of State.

(f) If the conditions described in paragraph (2) of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the department pursuant to paragraph (3) of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 7. Section 14005.13 of the Welfare and Institutions Code, as amended by Section 15 of Chapter 738 of the Statutes of 2022, is amended to read:

14005.13. (a) Notwithstanding Section 14005.12, when an individual residing in a long-term care facility would incur a ~~share of cost~~ long-term care patient liability for services under this chapter due to income that exceeds that allowed for the incidental and personal needs of the individual, a specified portion of the individual's earned income from therapeutic wages shall be exempt. Therapeutic wages are wages earned by the individual under all of the following conditions:

(1) A physician who does not have a financial interest in the long-term care facility in which the individual resides, and who is in charge of the individual's case, prescribes work as therapy for the individual.

(2) The individual must be employed within the same long-term care facility where they reside.

(3) The individual's employment does not displace any existing employees.

(4) The individual has resided in a long-term care facility for a continuous period commencing at least five years prior to the date of the addition of this section as originally adopted during the 1983–84 Regular Session.

(b) The amount of earned income from therapeutic wages that shall be exempt shall be the lesser of 70 percent of the gross therapeutic wages or 70 percent of the maintenance level as described in subdivision (b) of Section 14005.12.

(c) The provisions of this section shall be given retroactive effect for the period commencing June 1, 1983.

(d) This section shall not become operative unless and until the necessary waivers are obtained from the United States Department of Health and Human Services.

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-county letters, provider bulletins or notices, policy letters, or other similar instructions, without taking any further regulatory action. Within two calendar years of implementing subdivision (d) of Section 14005.12, the department shall adopt, amend, or repeal any necessary regulations.

(f) This section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (3) of subdivision (b) of Section 14005.12, as added by Section 73 of Chapter 47 of the Statutes of 2022, whichever is later.

SEC. 8. Section 14005.21 of the Welfare and Institutions Code is amended to read:

14005.21. (a) Any medically needy aged, blind, or disabled person who was categorically needy under this chapter on the basis of eligibility under Chapter 3 (commencing with Section 12000) or Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code for the month of August 1993, and was discontinued as of September 1, 1993, and who, but for the addition of Section 12200.015, would be eligible to receive benefits without a ~~share of cost~~ spend down of excess income in September 1993 under this chapter, shall remain eligible to receive benefits without a ~~share of cost~~ spend down of excess income under this chapter as if that person were categorically needy as long as ~~he or she meets~~ they meet other applicable requirements.

(b) Any medically needy aged, blind, or disabled person who was eligible for benefits under this chapter as categorically needy or medically needy under subdivision (a) for the month of August 1994, shall not be responsible for paying ~~his or her share of cost if he or she~~ their spend down of excess income if they had that eligibility for benefits without a ~~share of cost~~ spend down of excess income interrupted or terminated by the addition of Section 12200.017, and if ~~he or she,~~ they, but for Section 12200.017, would be eligible to continue receiving benefits under this chapter without a ~~share of cost.~~ spend down of excess income.

(c) Any medically needy aged, blind, or disabled person who was eligible for benefits under this chapter as categorically needy, or as medically needy under subdivision (a) or (b), for the calendar month immediately preceding the date that the reductions in maximum aid payments for the state supplementary program established in Chapter 3 (commencing with Section 12000) of Part 3 of Division 9 made in the 1995–96 Regular Session of the Legislature are effective shall not be responsible for paying ~~his or her share of cost if he or she had~~ their spend down of excess income if they had that eligibility for benefits without a ~~share of cost~~ spend down of excess income interrupted or terminated by the reductions in maximum aid payments, and if ~~he or she,~~ they, but for the reductions, would be eligible to continue receiving benefits under this chapter without a ~~share of cost.~~ spend down of excess income.

(d) Any medically needy aged, blind, or disabled person who was eligible for benefits under this chapter as categorically needy, or as medically needy under subdivisions (a), (b), or (c) for the calendar month immediately preceding the date that the reductions in maximum aid payments for the state supplementary program established in Chapter 3 (commencing with Section 12000) made in the 1996 portion of the 1995-96 Regular Session of the Legislature are effective shall not be responsible for paying ~~his or her share of cost if he or she~~ their spend down of excess income if

they had that eligibility for benefits without a ~~share of cost~~ spend down of excess income interrupted or terminated by the reductions in maximum aid payments, and if ~~he or she,~~ they, but for these reductions, would be eligible to continue receiving benefits under this chapter without a ~~share of cost.~~ spend down of excess income.

(e) The department shall implement this section regardless of the availability of federal financial participation for the ~~share of cost~~ spend down of excess income paid from state funds pursuant to subdivisions (a), (b), (c), and (d).

SEC. 9. Section 14005.26 of the Welfare and Institutions Code is amended to read:

14005.26. (a) (1) Except as provided in subdivision (b), the department shall exercise the option pursuant to Section 1902(a)(l0)(A)(ii)(XIV) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIV)) to provide full-scope benefits with no ~~share of cost~~ spend down of excess income under this chapter and Chapter 8 (commencing with Section 14200) to optional targeted low-income children pursuant to Section 1905(u)(2)(B) of the federal Social Security Act (42 U.S.C. Sec. 1396d(u)(2)(B)), with family incomes up to and including 200 percent of the federal poverty level. The department shall seek federal approval of a state plan amendment to implement this subdivision.

(2) (A) Pursuant to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)), the department shall adopt the option to use less restrictive income and resource methodologies to exempt all resources and disregard income at or above 200 percent and up to and including 250 percent of the federal poverty level for the individuals described in paragraph (1). The department shall seek federal approval of a state plan amendment to implement this subdivision.

(B) This paragraph shall be inoperative on January 1, 2014.

(b) Effective January 1, 2014, the federal poverty level percentage income eligibility threshold used pursuant to subdivision (c) of Section 14005.64 to determine eligibility for medical assistance under subdivision (a) shall equal 261 percent of the federal poverty level.

(c) For purposes of carrying out the provisions of this section, the department may adopt the option pursuant to Section 1902(e)(13) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(13)) to rely upon findings of the Managed Risk Medical Insurance Board (MRMIB) regarding one or more components of eligibility.

(d) (1) (A) Except as provided in subparagraph (B) and subparagraph (D) of paragraph (2), the department shall exercise the option pursuant to Section 1916A of the federal Social Security Act (42 U.S.C. Sec. 1396o-1) to impose premiums for individuals described in subdivision (a) whose family income has been determined to be above 150 percent and up to and including 200 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a). The department shall not impose premiums under this subdivision for individuals described in subdivision (a) whose family income has been determined to be at or below 150 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a). The department shall obtain federal approval for the implementation of this subdivision.

(B) Except as provided in subparagraph (D) of paragraph (2), the department shall impose a premium pursuant to subparagraph (A) for individuals whose family income has been determined to be above 160 percent and up to and including 261

percent of the federal poverty level, as determined, counted, and valued in accordance with the requirements of Section 14005.64.

(2) (A) Monthly premiums imposed under this section shall equal thirteen dollars ($13) per child with a maximum contribution of thirty-nine dollars ($39) per family.

(B) Families that pay three months of required premiums in advance shall receive the fourth consecutive month of coverage with no premium required. For purposes of the discount provided by this subparagraph, family contributions paid in the Healthy Families Program for children transitioned to Medi-Cal pursuant to Section 14005.27 shall be credited as Medi-Cal premiums paid.

(C) Families that pay the required premium by an approved means of electronic funds transfer, including credit card payment, shall receive a 25-percent discount from the required premium. If the department and the Managed Risk Medical Insurance Board determine that it is feasible, the department shall treat an authorization for electronic funds transfer or credit card payment to the Healthy Families Program as an authorization for electronic funds transfer or credit card payment to Medi-Cal.

(D) (i) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this section to the contrary, the department may elect not to impose premiums for an applicable coverage period on individuals whose family income has been determined to be above 160 percent and up to and including 261 percent of the federal poverty level as described in this subdivision.

(ii) If the department elects to not impose premiums for an applicable coverage period pursuant to clause (i) or elects to reinstate such premiums for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.

(e) This section shall be implemented only to the extent that all necessary federal approvals and waivers described in this section have been obtained and the enhanced rate of federal financial participation under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.) is available for targeted low-income children pursuant to that act.

(f) The department shall not enroll targeted low-income children described in this section in the Medi-Cal program until all necessary federal approvals and waivers have been obtained, and no sooner than January 1, 2013.

(g) (1) (A) Except as provided in subparagraph (B), to the extent the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is not fully operational, for the purposes of implementing this section, for individuals described in subdivision (a) whose family income has been determined to be up to and including 150 percent of the federal poverty level, as determined pursuant to paragraph (2) of subdivision (a), the department shall utilize the budgeting methodology for this population as contained in the November 2011 Medi-Cal Local Assistance Estimate for Medi-Cal county administration costs for eligibility operations.

(B) Effective January 1, 2014, to the extent the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is not fully operational, for purposes of implementing this section for individuals whose family income has been determined to be up to and including 160 percent of the federal poverty level, the department shall utilize the budgeting methodology for this population as contained in the November

2011 Medi-Cal Local Assistance Estimate for Medi-Cal county administration costs for eligibility operations.

(2) (A) Except as provided in subparagraph (B), for purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an amount for Medi-Cal eligibility operations associated with the individuals whose family income is determined to be above 150 percent and up to and including 200 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a). In developing an estimate for this activity, the department shall consider the projected number of final eligibility determinations each county will process and projected county costs. Within 60 days of the passage of the annual Budget Act, the department shall notify each county of their allocation for this activity based upon the amount allotted in the annual Budget Act for this purpose.

(B) Effective January 1, 2014, for purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an amount for Medi-Cal eligibility operations associated with the individuals whose family income is determined to be above 160 percent and up to and including 261 percent of the federal poverty level.

(h) When the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is fully operational, the new budget methodology shall be utilized to reimburse counties for eligibility determinations made for individuals pursuant to this section.

(i) Eligibility determinations and annual redeterminations made pursuant to this section shall be performed by county eligibility workers.

(j) In conducting eligibility determinations for individuals pursuant to this section and Section 14005.27, the following reporting and performance standards shall apply to all counties:

(1) Counties shall report to the department, in a manner and for a time period prescribed by the department, in consultation with the County Welfare Directors Association, the number of applications processed on a monthly basis, a breakout of the applications based on income using the federal percentage of poverty levels, the final disposition of each application, including information on the approved Medi-Cal program, if applicable, and the average number of days it took to make the final eligibility determination for applications submitted directly to the county and from the single point of entry (SPE).

(2) Notwithstanding any other law, the following performance standards shall be applied to counties regarding eligibility determinations for individuals eligible pursuant to this section:

(A) For children whose applications are received by the county human services department from the SPE, the following standards shall apply:

(i) Applications for children who are granted accelerated enrollment by the SPE shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(ii) Applications for children who are not granted accelerated enrollment by the SPE due to the existence of an already active Medi-Cal case shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(iii) For applications for children who are not described in clause (i) or (ii), 90 percent shall be processed within 10 working days of being received, complete and without client errors.

(iv) If an application described in this section also contains adults, and the adult applicants are required to submit additional information beyond the information provided for the children, the county shall process the eligibility for the child or children without delay, consistent with this section while gathering the necessary information to process eligibility for the adults.

(B) The department, in consultation with the County Welfare Directors Association, shall develop reporting requirements for the counties to provide regular data to the state regarding the timeliness and outcomes of applications processed by the counties that are received from the SPE.

(C) Performance thresholds and corrective action standards as set forth in Section 14154 shall apply.

(D) For applications submitted directly to the county, these applications shall be processed by the counties in accordance with the performance standards established under subdivision (d) of Section 14154.

(3) This subdivision shall be implemented no sooner than January 1, 2013.

(4) Twelve months after implementation of this section pursuant to subdivision (f), the department shall provide enrollment information regarding individuals determined eligible pursuant to subdivision (a) to the fiscal and appropriate policy committees of the Legislature.

(k) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, for purposes of this transition, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. It is the intent of the Legislature that the department be allowed temporary authority as necessary to implement program changes until completion of the regulatory process.

(2) To the extent otherwise required by Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall adopt emergency regulations implementing this section no later than July 1, 2014. The department may thereafter readopt the emergency regulations pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(*l*) To implement this section, the department may enter into and continue contracts with the Healthy Families Program administrative vendor, for the purposes of implementing and maintaining the necessary systems and activities for providing health care coverage to optional targeted low-income children in the Medi-Cal program for purposes of accelerated enrollment application processing by single point of entry, noneligibility-related case maintenance and premium collection, maintenance of the Health-E-App Web portal, call center staffing and operations, certified application assistant services, and reporting capabilities. To further implement this section, the

department may also enter into a contract with the Health Care Options Broker of the department for purposes of managed care enrollment activities. The contracts entered into or amended under this section may initially be completed on a noncompetitive bid basis and are exempt from the Public Contract Code. Contracts thereafter shall be entered into or amended on a competitive bid basis and shall be subject to the Public Contract Code.

(m) (1) If at any time the director determines that this section or any part of this section may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act, or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state, the director shall give notice to the fiscal and policy committees of the Legislature and to the Department of Finance. After giving notice, this section or any part of this section shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance, that it is necessary to cease to implement this section or a part or parts thereof, in order to receive federal financial participation, any increase in the federal medical assistance percentage available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state.

(2) The director shall retain the declaration described in paragraph (1), shall provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and shall post the declaration on the department's internet website.

(3) In the event that the director makes a determination under paragraph (1) and this section ceases to be implemented, the children shall be enrolled back into the Healthy Families Program.

SEC. 10. Section 14005.32 of the Welfare and Institutions Code is amended to read:

14005.32. (a) (1) If the county has evidence clearly demonstrating that a beneficiary is not eligible for benefits under this chapter pursuant to Section 14005.30, but is eligible for benefits under this chapter pursuant to other provisions of law, the county shall transfer the individual to the corresponding Medi-Cal program in conformity with and subject to the requirements of Section 14005.37. Eligibility under Section 14005.30 shall continue until the transfer is complete.

(2) The department, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers, shall prepare a simple, clear, consumer-friendly notice to be used by the counties to inform beneficiaries that their Medi-Cal benefits have been transferred pursuant to paragraph (1) and to inform them about the program to which they have been transferred. To the extent feasible, the notice shall be issued with the notice of discontinuance from cash aid, and shall include all of the following:

(A) A statement that Medi-Cal benefits will continue under another program, even though aid under Chapter 2 (commencing with Section 11200) has been terminated.

(B) The name of the program under which benefits will continue and an explanation of that program.

(C) A statement that continued receipt of Medi-Cal benefits will not be counted against any time limits in existence for receipt of cash aid under the CalWORKs program.

(D) A statement that the Medi-Cal beneficiary does not need to fill out monthly status reports in order to remain eligible for Medi-Cal, but may be required to submit annual reaffirmation forms. In addition, if the person or persons to whom the notice is directed has been found eligible for transitional Medi-Cal as described in Section 14005.8 or 14005.85, the statement shall explain the reporting requirements and duration of benefits under those programs and shall further explain that, at the end of the duration of these benefits, a redetermination, as provided in Section 14005.37, shall be conducted to determine whether benefits are available under any other law.

(E) A statement describing the beneficiary's responsibility to report to the county, within 10 days, significant changes that may affect eligibility or ~~share of cost.~~ spend down of excess income.

(F) A telephone number to call for more information.

(G) A statement that the beneficiary's eligibility worker will not change, or, if the case has been reassigned, the new worker's name, address, and telephone number, and the hours during which the county's Medi-Cal eligibility workers can be contacted.

~~(c)~~

(b) This section shall be implemented only to the extent that federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available.

~~(d)~~

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

~~(e)~~

(d) This section shall become operative on January 1, 2014.

SEC. 11. Section 14005.41 of the Welfare and Institutions Code is amended to read:

14005.41. (a) Notwithstanding any other ~~provision of~~ law, the department shall deem to have met the income documentation requirements for participation in the Medi-Cal program, without a ~~share of cost,~~ spend down of excess income, any child who is less than six years of age and who has been determined to be eligible for free meals through a federally funded program using the National School Lunch Program application provided for pursuant to Chapter 13 (commencing with Section 1751) of Title 42 of the United States Code.

(b) Notwithstanding any other ~~provision of~~ law, with regard to any child who is enrolled in and attending public school in the State of California, the department shall accept documentation of enrollment for free meals under the National School Lunch

Program as sufficient documentation of California residency for that child for the purposes of the Medi-Cal program.

(c) (1) (A) Notwithstanding any other ~~provision of~~ law, each county shall participate in a statewide pilot project to determine Medi-Cal program eligibility for any child under six years of age and currently enrolled in school in the State of California who is eligible for free meals under the National School Lunch Program upon receipt of proof of participation in the National School Lunch Program and a signed Medi-Cal application, which may be the supplemented application, described in subdivision (i). Counties shall notify the parent or guardian of the results of the eligibility determination.

(B) Notwithstanding any other ~~provision of~~ law, each county shall participate in a statewide pilot project to use the procedure described in this subdivision to determine Medi-Cal eligibility without a ~~share of cost,~~ spend down of excess income, and, if eligible, shall enroll in the Medi-Cal program, any child six years of age or older currently enrolled in school in the State of California who is eligible for free meals under the National School Lunch Program, upon receipt of proof of participation in the National School Lunch Program and a signed Medi-Cal application, which may be the supplemented application, described in subdivision (i). If the county determines from the supplemented application described in subdivision (i) that the child meets the eligibility requirements for participation in the Medi-Cal program, the county shall notify the parent or guardian that the child has been found eligible for the Medi-Cal program. If the county is unable to determine from the information on the application as described in subdivision (i) whether the child is eligible, the county shall contact the family to seek any additional information regarding income, household composition, or deductions that the department, in consultation with the county welfare departments, may determine to be necessary to complete the Medi-Cal application. If the county determines that the child does not meet the income eligibility requirements for participation in the full-scope no-cost Medi-Cal program, the county shall notify the parent or guardian of the determination and shall forward the school lunch application and any supplemental forms as described in subdivision (i) to the Healthy Families Program. If an applicant is determined to be ineligible for the full-scope no-cost Medi-Cal program and for the Healthy Families Program, the school lunch application and any supplemental forms as described in subdivision (i) shall be forwarded to a county- or local-sponsored health insurance program, as applicable, if the parent or guardian has provided consent. For purposes of this section, a county- or local-sponsored health insurance program includes a county agency, a local initiative, a county-organized health system, or other local entity that provides health care coverage to children who do not qualify for the full-scope no-cost Medi-Cal program or for the Healthy Families Program.

(2) Each county shall ask the parent or guardian of each child identified in subparagraph (A) of paragraph (1) and the parent or guardian of each child whom the county determines to meet the income eligibility requirements for participation in the Medi-Cal program under subparagraph (B) of paragraph (1) to provide additional documentation as required by current law necessary for retention of eligibility in the Medi-Cal program. If a parent or guardian does not provide the documentation required for retention of full-scope Medi-Cal program eligibility, the county shall continue the child's enrollment in the Medi-Cal program, but only for the limited scope of Medi-Cal

program benefits as described in Section 14007.5. If applicable, the county shall also forward the school lunch application and any supplemental forms as described in subdivision (i), for applicants who are determined to be ineligible for the full-scope no-cost Medi-Cal program and for the Healthy Families Program, to a county- or local-sponsored health insurance program if the parent or guardian has provided consent.

(d) Nothing in this section shall be construed as preventing the department from verifying eligibility through the Income Eligibility Verification System match mandated by Section 1137 of the federal Social Security Act (42 U.S.C. Sec. 1320b-7) or from requesting additional information or documentation required by federal law.

(e) Each county shall include its cost of implementing this section in its annual Medi-Cal administrative budget requests submitted to the department.

(f) For purposes of this section, the Medi-Cal program application date shall be the date on which the school lunch application information is received by the local agency determining eligibility under the Medi-Cal program.

(g) (1) This section shall be implemented only if, and to the extent that, federal financial participation is available for the services provided and only for the period of time the free National School Lunch Program utilizes a gross income standard at or below 133 percent of the federal poverty level. This section shall be implemented in a manner consistent with any federal approval.

(2) Notwithstanding paragraph (1), if the department determines that one or more state plan amendments are necessary to ensure full federal financial participation in the provisions of this section, the department shall prepare and submit requests for the state plan amendments to the federal government, after which this section shall not be implemented until the department receives approval of all necessary state plan amendments.

(h) (1) Notwithstanding subdivision (g), not later than March 1, 2003, the department, in consultation with the State Department of Education and representatives of the school districts, county superintendents of schools, local agencies that administer the Medi-Cal program, consumer advocates, and other stakeholders, shall develop and distribute the policies and procedures, including any all-county letters, necessary to implement Section 49557.2 of the Education Code and this section.

(2) The policies and procedures required to be developed and distributed pursuant to subdivision (a) shall include, at a minimum, both of the following:

(A) Processes for the school districts, county superintendents of schools, and local agencies that administer the Medi-Cal program to use in forwarding and processing free school lunch application information pursuant to Section 49557.2 of the Education Code, and in following up with the applicants to obtain any necessary documentation required by federal law.

(B) Instructions for implementing the eligibility provisions of this chapter.

(3) The policies and procedures required to be developed pursuant to subdivision (a) shall specify all of the following:

(A) The information on the school lunch application may be used to initiate a Medi-Cal program application only when the applicant has provided ~~his or her~~ their consent pursuant to Section 49557.2 of the Education Code.

(B) The date of the Medi-Cal program application shall be the date on which the school lunch application was received by the local agency that determines eligibility under the Medi-Cal program.

(C) The county, in determining eligibility for the Medi-Cal program, shall request additional documentation only as required by federal law, and shall enroll any child whose parent or guardian does not provide the necessary documentation for full-scope benefits under the Medi-Cal program in the Medi-Cal program with limited scope benefits, as described in Section 14007.5.

(i) To the extent federal financial participation is available, and to the extent administratively feasible, the department shall utilize the free National School Lunch Program application developed under Section 49557.2 of the Education Code, if supplemented as needed by simplified forms and disclosures, including Medi-Cal rights and responsibility notices and privacy notices, as a Medi-Cal application for children described in this section.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all-county letters or similar instructions without taking regulatory action. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(k) The department shall review the effectiveness of the statewide pilot project and make recommendations regarding appropriate ways to expand the use of the approaches contained in this section.

(*l*) In order to expedite health coverage for children who have been determined eligible for free meals under the National School Lunch Program, the department, at its discretion, may choose to implement this section in whole or in part by exercising the option described in Section 1396r-1a of Title 42 of the United States Code to allow information provided on the National School Lunch Program application referred to, and supplemented as described, in paragraph (1) of subdivision (a) of Section 49557.2 of the Education Code to serve as a basis for a preliminary eligibility determination by a qualified entity designated by the department.

(m) County- and local-sponsored health program agencies are authorized to use the supplemental application described in subdivision (i) and received pursuant to subdivision (c) to make an eligibility determination for those respective programs, and shall request additional information only as needed to complete the eligibility process.

(n) A county may, at its option, and with the consent of the parent or guardian as provided in paragraph (3) of subdivision (a) of Section 49557.2 of the Education Code, notify the school of the names and contact information of children who are in jeopardy of losing accelerated Medi-Cal coverage because a child's parent or guardian has not provided required followup information to the county. This notice shall be limited to the names and contact information, and shall not specify what information is missing. This shall be done for the sole purpose of enabling the school, at its option, to conduct outreach activities to encourage or assist those parents or guardians to complete and submit the required followup information.

SEC. 12. Section 14005.42 of the Welfare and Institutions Code is amended to read:

14005.42. (a) The department shall provide full-scope benefits under this chapter, without ~~share of cost,~~ spend down of excess income, to all individuals on behalf of whom kinship guardians are receiving aid under any of the Kinship Guardian

Assistance Payment Programs pursuant to Article 4.5 (commencing with Section 11360) of Chapter 2.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department and the State Department of Social Services may implement, without taking regulatory action, this section by means of all county letters or similar instruction. Thereafter, as needed, the departments shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) To the extent that federal financial participation is not available, the cost of benefits provided under this section shall be covered only by state funds.

(d) The department and the State Department of Social Services shall work cooperatively to develop procedures that maximize the availability of federal financial participation for the cost of benefits provided under this section. The procedures shall include conforming the application and eligibility determination process for this population to meet the requirements of federal Medicaid law.

SEC. 13. Section 14005.95 is added to the Welfare and Institutions Code, to read:

14005.95. (a) For persons in long-term care, any income deductions, with the exception of other health insurance premiums under Sections 14005.4 and 14005.7, shall not be deducted in the post-eligibility treatment of income determination pursuant to Section 14051.7 to the extent allowable under federal law or regulations.

(b) Once the beneficiary has medical expenses that are not subject to payment by a third party and are equal to or exceed their long-term care patient liability amount, the individual is entitled to receive health care services pursuant to Section 14005 if all other applicable eligibility criteria established pursuant to this chapter are met. Those medical expenses may include, but are not limited to, any of the following:

(1) Medicare health insurance deductibles and coinsurance charges.

(2) Other health insurance deductibles and coinsurance charges.

(3) Necessary medical and remedial services.

(4) Expected expenses for inpatient long-term care in a medical facility.

SEC. 14. Section 14006.4 of the Welfare and Institutions Code is amended to read:

14006.4. (a) The statement required by Sections 14006.2 and 14006.3 shall be in the following form:

"NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY

If you or your spouse is in or is entering a nursing facility, read this important message!

You or your spouse do not have to use all your resources, such as savings, before Medi-Cal might help pay for all or some of the costs of a nursing facility.

You should be aware of the following to take advantage of these provisions of the law:

UNMARRIED RESIDENT

An unmarried resident is financially eligible for Medi-Cal benefits if ~~he or she has~~ they have less than (insert amount of individual's resource allowance) in available resources. A home is an exempt resource and is not considered against the resource limit, as long as the resident states on the Medi-Cal application that ~~he or she intends~~ they intend to return home. Clothes, household furnishings, irrevocable burial plans, burial plots, and an automobile are examples of other exempt resources.

If an unmarried resident is financially eligible for Medi-Cal reimbursement, ~~he or she is~~ they are allowed to keep from ~~his or her~~ their monthly income a personal allowance of (insert amount of personal needs allowance) plus the amount of health insurance premiums paid monthly. The remainder of the monthly income is paid to the nursing facility as a monthly deductible called the "Medi-Cal ~~share of cost."~~ long-term care patient liability."

MARRIED RESIDENT

If one spouse lives in a nursing facility, and the other spouse does not live in a nursing facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than (insert amount of Community Spouse Resource Allowance plus individual's resource allowance) in available assets. The couple's home will not be counted against this (insert amount of Community Spouse Resource Allowance plus individual's resource allowance), as long as one spouse or a dependent relative, or both, lives in the home, or the spouse in the nursing facility states on the Medi-Cal application that ~~he or she intends~~ they intend to return to the couple's home to live.

If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least ~~his or her~~ their individual monthly income or (insert amount of Minimum Monthly Maintenance Needs Allowance), whichever is greater. Of the couple's remaining monthly income, the spouse in the nursing facility is allowed to keep a personal allowance of (insert amount of personal needs allowance) plus the amount of health insurance premiums paid monthly. The remaining money, if any, generally must be paid to the nursing facility as the Medi-Cal ~~share of cost.~~ long-term care patient liability. The Medi-Cal program will pay remaining nursing facility costs.

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge that will allow the at-home spouse to retain additional resources or income. Such an order can allow the couple to retain more than (insert amount of Community Spouse Resource Allowance plus individual's resource allowance) in available resources, if the income that could be generated by the retained resources would not cause the total monthly income available to the at-home spouse to exceed (insert amount of Monthly Maintenance Needs Allowance). Such an order also can allow the at-home spouse to retain more than (insert amount of Monthly Maintenance Needs Allowance) in monthly income, if the extra income is necessary "due to exceptional circumstances resulting in significant financial duress."

An at-home spouse also may obtain a court order to increase the amount of income and resources that ~~he or she is~~ they are allowed to retain, or to transfer property

from the spouse in the nursing facility to the at-home spouse. You should contact a knowledgeable attorney for further information regarding court orders.

The paragraphs above do not apply if both spouses live in a nursing facility and neither previously has been granted Medi-Cal eligibility. In this situation, the spouses may be able to hasten Medi-Cal eligibility by entering into an agreement that divides their community property. The advice of a knowledgeable attorney should be obtained prior to the signing of this type of agreement.

Note: For married couples, the resource limit ((insert amount of Community Spouse Resource Allowance plus individual's resource allowance) in (insert current year)) and income limit ((insert amount of Minimum Monthly Maintenance Needs Allowance) in (insert current year)) generally increase a slight amount on January 1 of every year.

TRANSFER OF HOME FOR BOTH A MARRIED AND AN UNMARRIED RESIDENT

A transfer of a property interest in a resident's home will not cause ineligibility for Medi-Cal reimbursement if either of the following conditions is met:

(a) At the time of transfer, the recipient of the property interest states in writing that the resident would have been allowed to return to the home at the time of the transfer, if the resident's medical condition allowed ~~him or her~~ them to leave the nursing facility. This provision shall only apply if the home has been considered an exempt resource because of the resident's intent to return home.

(b) The home is transferred to one of the following individuals:

(1) The resident's spouse.

(2) The resident's minor or disabled child.

(3) A sibling of the resident who has an equity interest in the home, and who resided in the resident's home for at least one year immediately before the resident began living in institutions.

(4) A ~~son or daughter~~ child of the resident who resided in the resident's home at least two years before the resident began living in institutions, and who provided care to the resident that permitted the resident to remain at home longer.

This is only a brief description of the Medi-Cal eligibility rules, for more detailed information, you should call your county welfare department. You will probably want to consult with the local branch of the state long-term care ombudsman, an attorney, or a legal services program for seniors in your area.

I have read the above notice and have received a copy.

Dated: _____ Signature: _____"

(b) The statement required by subdivision (a) shall be printed in at least 10-point type, shall be clearly separate from any other document or writing, and shall be signed by the person to be admitted and that person's spouse, and legal representative, if any.

(c) Any nursing facility that willfully fails to comply with this section shall be subject to a class "B" citation, as defined by Section 1424 of the Health and Safety Code.

(d) The department may revise this statement as necessary to maintain its consistency with state and federal law.

SEC. 15. Section 14009 of the Welfare and Institutions Code is amended to read:

14009. (a) Any applicant for, or beneficiary of Medi-Cal, or person acting on behalf of an applicant or beneficiary shall be informed as to the provisions of eligibility and, in writing, of ~~his or her~~ their responsibility for reporting facts material to a correct determination of eligibility and ~~share of cost.~~ spend down of excess income.

(b) Any applicant for, or beneficiary of Medi-Cal, or person acting on behalf of an applicant or beneficiary shall be responsible for reporting accurately and completely within ~~his or her~~ their competence those facts required of ~~him or her~~ them pursuant to subdivision (a) and to report promptly any changes in those facts.

(c) If, because of a failure to report facts in accordance with subdivision (b), the beneficiary received health care to which ~~he or she was not entitled, he or she~~ they were not entitled, they shall be liable to repay any overpayment. The amount of overpayment shall be based on the amount of excess income or resources and computed in accordance with overpayment regulations promulgated by the director.

(d) No liability for overpayment shall result from circumstances where there is a failure on the part of an applicant or beneficiary to perform an act constituting a condition of eligibility, if the failure is caused by an error made by the department or a county welfare department, or where the beneficiary reported facts in accordance with subdivision (b) but a county welfare department failed to act on those facts.

(e) When the department determines that an overpayment has occurred, the department shall seek to recover the full amount of the overpayment by appropriate action under state law against the income or resources of the beneficiary or the income and resources of any person who is financially responsible for the cost of ~~his or her~~ their health care pursuant to Section 14008.

(f) The department shall advise the beneficiary of the overpayment, the amount ~~he or she is~~ they are liable to repay, and of ~~his or her~~ their entitlement to a hearing on the propriety of the action pursuant to Chapter 7 (commencing with Section 10950) of Part 2.

(g) No civil or criminal action may be commenced against any person based on alleged unlawful application for or receipt of health care services, where the case record of the person has been destroyed after the expiration of the retention period provided pursuant to Section 10851.

SEC. 16. Section 14011 of the Welfare and Institutions Code is amended to read:

14011. (a) Each applicant who is not a recipient of aid under the provisions of Chapter 2 (commencing with Section 11200) or Chapter 3 (commencing with Section 12000) shall be required to file an affirmation setting forth such facts about ~~his~~ their annual income and other resources and qualifications for eligibility as may be required by the department. Such statements shall be on forms prescribed by the department.

(b) To the extent permitted by federal law, eligibility for medical assistance for such applicants shall not be granted until the applicant or designated representative provides independent documentation verifying statements of gross income by type and source; income amounts withheld for taxes, health care benefits available through employment, retirement, military service, work related injuries or settlements from prior injuries, employee retirement contributions, and other employee benefit contributions, deductible expenses for maintenance or improvement of

income-producing property and status and value of property owned, other than property exempt under Section 14006. The director may prescribe those items of exempt property ~~which~~ that the director deems should be verified as to status and value in order to reasonably assure a correct designation of those items as exempt.

(c) The verification requirements of subdivision (b) apply to income, income deductions and property both of applicants for medical assistance (other than applicants for public assistance) and to persons whose income, income deductions, expenses or property holdings must be considered in determining the applicant's eligibility and ~~share of cost.~~ spend down of excess income.

(d) A determination of eligibility and ~~share of cost~~ spend down of excess income may be extended beyond otherwise prescribed time frames if, in the county department's judgment, and subject to standards of the director, the applicant or designated representative has good cause for failure to provide the required verification and continues to make a good faith effort to provide such verification.

(e) To the extent permitted by federal law, in addition to the other verification requirements of this section, a county department may require verification of any other applicant statements, or conduct a full and complete investigation of the statements, whenever a verification or investigation is warranted in the judgment of the county department.

(f) If documentation is unavailable, as defined in regulations promulgated by the department, the applicant's signed statement as to the value or amount shall be deemed to constitute verification.

SEC. 17. Section 14011.65 of the Welfare and Institutions Code is amended to read:

14011.65. (a) To the extent allowed under federal law and only if federal financial participation is available under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.), the state shall administer the Medi-Cal to Healthy Families Accelerated Enrollment program, to provide any child who meets the criteria set forth in subdivision (b) with temporary health benefits for the period described in paragraph (2) of subdivision (b), as established under Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(b) (1) Any child who meets all of the following requirements, shall be eligible for temporary health benefits under this section:

(A) The child, or ~~his or her~~ their parent or guardian, submits an application for the Medi-Cal program directly to the county.

(B) The child's income, as determined on the basis of the application described in subparagraph (A), is within the income limits established by the Healthy Families Program.

(C) The child is under 19 years of age at the time of the application.

(D) The county determines, on the basis of the application described in subparagraph (A), that the child is eligible for full scope Medi-Cal with a ~~share of cost.~~ spend down of excess income.

(E) The child is not receiving Medi-Cal benefits at the time that the application is submitted.

(F) The child, or ~~his or her~~ their parent or guardian, gives, or has given consent for the application to be shared with the Healthy Families Program for purposes of determining the child's Healthy Families Program eligibility.

(2) The period of accelerated eligibility provided for under this section begins on the first day of the month that the county finds that the child meets all of the criteria described in paragraph (1) and concludes on the last day of the month that the child either is fully enrolled in, or has been determined ineligible for, the Healthy Families Program.

(3) For any child who meets the requirements for temporary health benefits under this section, the county shall forward to the Healthy Families Program sufficient information from the child's application to determine eligibility for the Healthy Families Program. To the extent possible, submission of that information to the Healthy Families Program shall be accomplished using an electronic process developed for use in the Medi-Cal-to-Healthy Families Bridge Benefits Program. The department shall give the Healthy Families Program a daily electronic file of all children provided temporary health benefits pursuant to this section.

(4) The temporary health benefits provided under this section shall be identical to the benefits provided to children who receive full-scope Medi-Cal benefits without ~~a share of cost~~ spend down of excess income and shall only be made available through a Medi-Cal provider.

(c) The department, in consultation with the Managed Risk Medical Insurance Board and representatives of the local agencies that administer the Medi-Cal program, consumer advocates, and other stakeholders, shall develop and distribute the policies and procedures, including any all-county letters, necessary to implement this section.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all-county letters or similar instructions, without taking any further regulatory action. Thereafter, the department may adopt regulations, as necessary, to implement this section in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(e) The department shall seek approval of any amendments to the state plan necessary to implement this section, in accordance with Title XIX (42 U.S.C. Sec. 1396 et seq.) of the Social Security Act. Notwithstanding any other ~~provision of~~ law, only when all necessary federal approvals have been obtained shall this section be implemented.

(f) Under no circumstances shall this section be implemented unless the state has sought and obtained approval of any amendments to its state plan, as described in Section 12693.50 of the Insurance Code, necessary to implement this section and obtain funding under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.) for the provision of benefits provided under this section. Notwithstanding any other ~~provision of~~ law, and only when all necessary federal approvals have been obtained by the state, this section shall be implemented only to the extent federal financial participation under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.) is available to fund benefits provided under this section.

(g) The department shall commence implementation of this section on the first day of the third month following the month in which federal approval of the state plan amendment or amendments described in subdivision (f), and subdivision (b) of Section 12693.50 of the Insurance Code is received, or on August 1, 2006, whichever is later.

(h) This section shall cease to be implemented on the date that the director executes a declaration, pursuant to subdivision (h) of Section 14011.65, stating that

implementation of Section 14011.65a has commenced. Implementation of this section shall resume on the date that Section 14011.65a becomes inoperative, pursuant to subdivision (h) of that section.

SEC. 18. Section 14011.8 of the Welfare and Institutions Code is amended to read:

14011.8. (a) Benefits provided to an individual pursuant to a preliminary determination as described in Section 1396r-1, 1396r-1a, or 1396r-1b of Title 42 of the United States Code shall end, without the necessity for any further review or determination by the department, on or before the last day of the month following the month in which the preliminary determination was made, unless an application for medical assistance under the state plan is filed on or before that date.

(b) If an application for medical assistance is filed on or before the last day of the month following the month in which the preliminary determination was made, preliminary benefits shall continue until the regular eligibility determination based on the application has been completed. The application shall be treated in all respects as an initial application for benefits and the following shall apply:

(1) In the case of an applicant who is found eligible for medical assistance, benefits shall be granted in an amount and under those conditions, including imposition of a ~~share of cost,~~ spend down of excess income, as have been found applicable pursuant to the regular eligibility determination.

(2) In the case of all other applicants, provision of preliminary benefits shall end on the day that the regular eligibility determination is made.

(c) Notwithstanding any other ~~provision of~~ law, medical assistance pursuant to a preliminary determination as described in Section 1396r-1, 1396r-1a, or 1396r-1b of Title 42 of the United States Code shall be provided only if and to the extent federal financial participation is available.

SEC. 19. Section 14015 of the Welfare and Institutions Code is amended to read:

14015. (a) (1) The providing of health care under this chapter shall not impose any limitation or restriction upon the person's right to sell, exchange or change the form of property holdings nor shall the care provided constitute any encumbrance on the holdings. However, the transfer or gift of assets, including income and resources, for less than fair market value shall, pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act, result in a period of ineligibility for medical assistance for home and facility care, which may include partial months of ineligibility, applied in accordance with federal law.

(2) Any items, including notes, loans, life estates, or annuities that are held and distributed in a manner that is not in conformity with the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and regulations adopted pursuant to that act, shall be treated as a transferred asset and may result in a period of ineligibility as described in paragraph (1), as required by Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act.

(b) Pursuant to Section 1917 (c)(2)(C)(ii) of the federal Social Security Act (42 U.S.C. Sec. 1396p(c)(2)(C)(ii)), a satisfactory showing that assets transferred exclusively

for a purpose other than to qualify for medical assistance shall not result in ineligibility for Medi-Cal and shall include, but not be limited to, the following:

(1) Assets that would have been considered exempt for purposes of establishing eligibility pursuant to federal or state laws at the time of transfer.

(2) Property with a net market value that, when the property is transferred, if included in the property reserve, would not result in ineligibility.

(3) Assets for which adequate consideration is received.

(4) Property upon which foreclosure or repossession was imminent at the time of transfer, provided there is no evidence of collusion.

(5) Assets transferred in return for an enforceable contract for life care that does not include complete medical care.

(6) Assets transferred without adequate consideration, provided that the applicant or beneficiary provides convincing evidence to overcome the presumption that the transfer was for the purpose of establishing eligibility or reducing the ~~share of cost.~~ spend down of excess income.

(c) In administering this section, it shall be presumed that assets transferred by the applicant or beneficiary prior to the look-back period established by the department preceding the date of initial application were not transferred to establish eligibility or reduce the ~~share of cost.~~ spend down of excess income. These assets shall not be considered in determining eligibility.

(d) Any item of durable medical equipment ~~which~~ that is purchased for a recipient pursuant to this chapter exclusively with Medi-Cal program funds shall be returned to the department when the department determines that the item is no longer medically necessary for the recipient. Items of durable medical equipment shall include, but are not limited to, wheelchairs and special hospital beds.

(e) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act, and only to the extent that federal financial participation is available.

(f) To the extent that regulations are necessary to implement this section, the department shall promulgate regulations using the nonemergency regulatory process described in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

(g) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this act are filed with the Secretary of State.

SEC. 20. Section 14015.12 of the Welfare and Institutions Code is amended to read:

14015.12. (a) For the purposes of this section, the following definitions shall apply:

(1) “Opposite-sex spouse” means a person of the opposite sex who is legally married to an applicant for, or recipient of, home and facility care.

(2) “Registered domestic partner” means a person that meets the requirements of Section 297 of the Family Code and with whom the applicant for, or recipient of, home and facility care shares the common residence.

(3) “Same-sex spouse” means a person of the same sex who is legally married to an applicant for, or recipient of, home and facility care.

(b) In addition to the requirements of Section 14015.1, the department shall consider, at initial application or redetermination, whether an undue hardship, as described in subdivision (c), exists prior to finding that an applicant or recipient is subject to a period of ineligibility for medical assistance for home and facility care pursuant to this article. No person shall be subject to a period of ineligibility for medical assistance for home and facility care at the time of the initial application or redetermination if the department determines that an undue hardship exists.

(c) An undue hardship shall be found to exist under any of the following circumstances:

(1) The applicant for, or recipient of, home and facility care transferred all or any portion of ~~his or her~~ their ownership interest in the shared principal residence to ~~his or her~~ their same-sex spouse or registered domestic partner.

(2) (A) Subject to the requirements of subparagraph (B), the applicant for, or recipient of, home and facility care transferred ~~his or her~~ their ownership interest in resources other than the shared principal residence to ~~his or her~~ their same-sex spouse or registered domestic partner and the value of those resources does not exceed the value of resources that the individual could transfer to ~~his or her~~ their same-sex spouse or registered domestic partner and does not exceed the community spouse resource allowance that would be available to that person if ~~he or she was~~ they were an opposite-sex spouse. When considering whether an undue hardship exists under this paragraph, the Medi-Cal eligibility determination rules applicable to resource evaluations for an applicant for, or recipient of, home and facility care and ~~his or her~~ their opposite-sex spouse shall be used to determine the resources available to an applicant for, or recipient of, home and facility care and ~~his or her~~ their same-sex spouse or registered domestic partner.

(B) If the value of the resources transferred exceeds the limit specified in subparagraph (A), the amount of resources transferred that meet the limit shall be subject to the undue hardship exception specified in subparagraph (A) and the amount of resources transferred in excess of the limit shall not be subject to an undue hardship exception under this section and shall be considered a transfer of assets for less than fair market value.

(3) (A) Subject to the requirements of subparagraph (B), the applicant for, or recipient of, home and facility care transferred ~~his or her~~ their income or right to receive income to ~~his or her~~ their same-sex spouse or registered domestic partner and the amount of the transferred income does not exceed the amount of income that the individual could transfer to ~~his or her~~ their same-sex spouse or registered domestic partner and does not exceed the maximum monthly spousal income allowance that would be available to that person if ~~he or she was~~ they were an opposite-sex spouse. When considering whether an undue hardship exists under this paragraph, the Medi-Cal eligibility determination rules applicable to income evaluations for an applicant for, or recipient of, home and facility care and ~~his or her~~ their opposite-sex spouse shall be used to determine the income available to an applicant for, or recipient of, home and facility care and ~~his or her~~ their same-sex spouse or registered domestic partner.

(B) If the amount of income transferred exceeds the limit specified in subparagraph (A), the amount of income transferred that meets the limit shall be subject to the undue hardship exception specified in subparagraph (A) and the amount of income transferred in excess of the limit shall not be subject to an undue hardship

exception under this section and shall continue to be included in the applicant's or recipient's ~~share of cost.~~ spend down of excess income. To the extent that the excess income transferred was the applicant's or recipient's right to receive a future income stream and that transfer can be revoked, the applicant or recipient shall revoke the transfer. To the extent that the transferred income stream cannot be revoked, that future income stream shall be considered a transfer of assets for less than fair market value.

(d) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act.

(e) (1) The department shall submit a state plan amendment or seek other federal approval before implementing the undue hardship circumstances identified in this section. The department shall request, in the state plan amendment or other federal approval request, that the effective date of approval be retroactive to January 1, 2012.

(2) This section shall be implemented only if, and to the extent that, a state plan amendment is approved or other federal approval is obtained and federal financial participation is available.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all-county letters or similar instructions, without taking regulatory action.

SEC. 21. Section 14016 of the Welfare and Institutions Code is amended to read:

14016. (a) The county in which the person resides, except as specified in subdivision (d), shall determine the eligibility of each person pursuant to Sections 14005.1, 14005.4, and 14005.7 and Article 4.4 (commencing with Section 14140), except that the department may contract with the federal Social Security Administration for the determination of Medi-Cal eligibility of persons eligible under Title XVI of the Social Security Act. Upon termination of such assistance, the county shall determine whether the person remains eligible for Medi-Cal coverage under one of these sections.

(b) The department shall institute an eligibility quality control program, to verify the eligibility determination of a sample of persons in each county granted Medi-Cal eligibility under Section 14005.4, 14005.7, or 14005.8 or Article 4. 4 (commencing with Section 14140).

(c) A review period shall be defined as one year and shall coincide with the federal fiscal year. The department shall draw a random sample of cases for each period. The random sample shall be drawn to ensure a minimum number of cases reviewed in each county in each review period according to the following:

(1) All cases shall be sampled in any county with less than 50 Medi-Cal cases.

(2) Fifty cases in any county with greater than 0.01 percent and less than or equal to .50 percent of the Medi-Cal cases.

(3) Seventy-five cases in any county with greater than .50 percent and less than or equal to 1 percent of the Medi-Cal cases.

(4) One hundred cases in any county with greater than 1 percent and less than or equal to 3 percent of the Medi-Cal cases.

(5) One hundred twenty-five cases in any county with greater than 3 percent and less than or equal to 10 percent of the Medi-Cal cases.

(6) Six hundred fifty cases in any county with greater than 10 percent of the Medi-Cal cases.

(d) When family members maintain separate residences, but eligibility is determined as a single unit because of the provisions of Section 14008, the county in which the parent or parents reside shall determine the eligibility for the entire unit.

(e) In administering the provisions of law and regulations related to eligibility determination the director shall impose such fiscal penalties as provided by this section to assure adequate county administrative performance.

(f) The director shall hold counties financially liable for payments made on behalf of ineligible persons or persons with an incorrect ~~share of cost.~~ spend down of excess income. When a sample case is found to include an ineligible person or a person with an understated ~~share of cost,~~ spend down of excess income, written notification shall be sent to the county department ~~which~~ that describes the error and requests a written response within two weeks. The county shall indicate whether it agrees or disagrees with the findings. If the county disagrees, the department shall reevaluate the error findings, taking into consideration any additional facts contained in the county's response. The department shall again notify the county of the department's findings. If the county continues to disagree with the error findings, the county may appeal to the Chief of the Medi-Cal Policy Division, requesting that the department review the case and render a final decision. The director may reduce or waive the fiscal liability of a county if the department is unable to meet the minimum sample required, as defined in subdivision (c), or if an individual county experienced a natural disaster, job actions, or other occurrences ~~which~~ that impacted the findings in an individual county as determined by the director.

(g) The department shall utilize the methodology detailed in this subdivision to establish counties' fiscal penalties. The department shall determine each county's case error rate for each review period by dividing the number of completed case reviews in that county found in error by the number of case reviews in that county. State caused errors shall be determined by the department and shall not be included in this calculation. Case error rates shall be arrayed from highest to lowest. From this array, the department shall determine the percentage of counties liable as follows:

(1) The 60 percent of counties with the highest case error rates shall be liable if the state's dollar error rate exceeds the federal standard by 0.01 percent to 1 percent.

(2) The 70 percent of counties with the highest case error rates shall be liable if the state's dollar error rate exceeds the federal standard by greater than 1 percent and less than or equal to 2 percent.

(3) The 80 percent of counties with the highest case error rates shall be liable if the state's dollar error rate exceeds the federal standard by greater than 2 percent and less than or equal to 3 percent.

(4) The 90 percent of counties with the highest case error rates shall be liable if the state's dollar error rate exceeds the federal standard by greater than 3 percent and less than or equal to 4 percent.

(5) All counties shall be liable if the state's dollar error rate exceeds the federal standard by greater than 4 percent.

As used herein, "the state's dollar error rate" means the Medicaid dollar error rate reported to the department by the United States Department of Health and Human Services, less any portion of this error rate attributable to state caused errors. The term

"federal standard" means the Medicaid dollar error rate standard to which the state is held accountable.

For each county determined liable, the department shall calculate a penalty multiple ~~which~~ that shall be the product of a liable county's case error rate multiplied by the liable county's percentage of statewide Medi-Cal cases. Each county's fiscal penalty shall be the product of a county's penalty multiple divided by the sum of all penalty multiples, multiplied times the penalty bank. The penalty bank includes only quality control federal fiscal sanctions, federal withholds, federal disallowances, and any associated General Fund expenditures, minus the value of any state assumed errors and the General Fund share of the value of client caused errors. The case error rate and penalty multiple shall be adjusted by excluding client errors for the purpose of determining the associated General Fund expenditures.

If, after the department has assessed penalties to counties, the federal government reduces or eliminates any quality control federal fiscal sanction, federal withhold or federal disallowance, the department shall reduce or eliminate the corresponding fiscal penalty assessment including any associated General Fund expenditures to liable counties.

(h) When a county welfare department contravenes state eligibility processing regulations and written instructions in a way that produces increased program benefits or administrative expenses but doesn't result in an increase in the eligibility dollar error rate, the director shall recoup from that county the additional administrative or program benefit costs above those ~~which~~ that would have been incurred had that county not contravened the established state eligibility processing regulations and written instructions. This section shall not be construed to interfere with the rights of counties to out-station eligibility staff.

Notwithstanding the number of counties determined liable for fiscal penalties under this section, individual county corrective action plans as prescribed by the department shall be required from all counties ~~which~~ that exceed a 15 percent case error rate.

(i) Any penalties imposed under this system shall be collected through direct repayment from liable counties rather than through any reduction in funds otherwise due to counties.

SEC. 22. Section 14019.4 of the Welfare and Institutions Code is amended to read:

14019.4. (a) A provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility pursuant to this chapter shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient, or a person other than the department or a third-party payor who provides a contractual or legal entitlement to health care services.

(b) Whenever a service or set of services rendered to a Medi-Cal beneficiary results in the submission of a claim in excess of five hundred dollars ($500), and the beneficiary has given the provider proof of eligibility to receive the service or services, the provider shall issue the beneficiary a receipt to document that appropriate proof of eligibility has been provided. The form and content of those receipts shall be determined by the provider but shall be sufficient to comply with the intent of this subdivision.

Nursing facilities and all categories of intermediate care facilities for the developmentally disabled are exempt from the requirements of this subdivision.

(c) In addition to being subject to applicable sanctions set forth in law or regulation, a provider of health care services who obtains a label from, or copy of, the Medi-Cal card or other proof of eligibility pursuant to this chapter, and who subsequently pursues reimbursement or payment for the cost of covered services from the beneficiary or fails to cease collection efforts against the beneficiary for covered services as required by subdivision (d), may be subject to a penalty, payable to the department, not to exceed three times the amount payable by the Medi-Cal program. In implementing this subdivision, mitigating circumstances, which include, but are not limited to, clerical error and good faith mistake, shall be considered when assessing the penalty. Providers subject to penalties under this subdivision shall have the right to appeal the assessed penalty, consistent with department procedures.

(d) When a Medi-Cal provider receives proof of a patient's Medi-Cal eligibility and that provider has previously referred an unpaid bill for services rendered to the patient to a debt collector, the Medi-Cal provider shall promptly notify the debt collector of the patient's Medi-Cal coverage, instruct the debt collector to cease collection efforts on the unpaid bill for the covered services, and notify the patient accordingly.

(e) If a patient provides proof of Medi-Cal eligibility to a debt collector, and the debt collector fails to notify the provider of this proof, the provider shall not be responsible for ensuring that collection efforts against the patient cease pursuant to subdivision (d) until either the patient or the debt collector provides the provider with proof of the patient's Medi-Cal eligibility.

(f) A Medi-Cal provider or debt collector shall be deemed to be in violation of subdivision (a) of Section 1785.25 of the Civil Code if more than 30 days after receiving proof of Medi-Cal coverage the provider or debt collector does either of the following:

(1) Furnishes information regarding the rendering of the Medi-Cal covered services to a consumer credit reporting agency.

(2) Fails to provide corrections of, or instructions to delete, as appropriate, information regarding Medi-Cal covered services previously furnished by that Medi-Cal provider or debt collector to a consumer reporting agency.

(g) This section shall not apply to the Medi-Cal ~~share of cost~~ spend down of excess income owed by a Medi-Cal beneficiary, unless the beneficiary's ~~share of cost~~ spend down of excess income has been met for the month in which services were rendered.

(h) For purposes of this section, "debt collector" includes any person who regularly engages in debt collection, as defined by Section 1788.2 of the Civil Code, but does not include the original Medi-Cal provider.

SEC. 23. Section 14051.7 is added to the Welfare and Institutions Code, to read:

14051.7. "Post-eligibility treatment of income" means the determination of long-term care patient liability for each month in which the patient is described in Section 14050.3 or as an institutionalized spouse described in Section 14002.5 determined in accordance with Section 435.725 of Title 42 of the Code of Federal Regulations, without regard to paragraph (1) of subsection (b) of that section, and Sections 435.832, and 435.845 of Title 42 of the Code of Federal Regulations, as appropriate.

SEC. 24. Section 14051.8 is added to the Welfare and Institutions Code, to read:

14051.8. "Long-term care patient liability" is the term given to the result of the post-eligibility treatment of income calculation under Section 14051.7. The person in long-term care or an institutionalized spouse shall incur or expect to incur an amount of medical expenses that equal this amount pursuant to subdivision (d) of Section 14005.12.

SEC. 25. Section 14054 of the Welfare and Institutions Code is amended to read:

14054. ~~"Share of cost"~~ (a) "Share of cost" or "spend down of excess income" means the amount of the costs of health care ~~which~~ that a person or family eligible under Section 14005.4 or 14005.7 ~~must~~ shall incur prior to being certified by the department as specified in Section 14018.

(b) Upon the effective date of the act that added this subdivision, any reference to "share of cost" in this chapter or elsewhere in this code that relates to an individual Medi-Cal beneficiary's or applicant's eligibility under the medically needy persons or medically needy family persons categories shall be read as "spend down of excess income" and the definition in subdivision (a) shall apply.

SEC. 26. Section 14110.8 of the Welfare and Institutions Code is amended to read:

14110.8. (a) For the purposes of this section:

(1) "Facility" means any long-term health care facility as defined in subdivisions (c), (d), (e), (g), and (h) of Section 1250 of the Health and Safety Code.

(2) "Resident" means a person who is a facility resident or patient and a Medi-Cal beneficiary and whose facility care is being paid for in whole or in part by Medi-Cal.

(3) "Agent" means a person who manages, uses, or controls those funds or assets of the resident that legally are required to be used to pay the resident's ~~share of cost~~ long-term care patient liability and other charges not paid for by the Medi-Cal program.

(4) "Responsible party" means a person other than the resident or potential resident, who, by virtue of signing or cosigning an admissions agreement of a facility, either together with, or on behalf of, a potential resident, becomes personally responsible or liable for payment of any portion of the charges incurred by the resident while in the facility. A person who signs or cosigns a facility's admissions agreement by virtue of being an agent under a power of attorney for health care or an attorney-in-fact under a durable power of attorney executed by the potential resident, a conservator of the person or estate of the potential resident, or a representative payee, is not a responsible party under this section, and does not thereby assume personal responsibility or liability for payment of any charges incurred by the resident, except to the extent that the person, or the resident's conservator or representative payee is an agent as defined in paragraph (3).

(b) No facility may require or solicit, as a condition of admission into the facility, that a Medi-Cal beneficiary have a responsible party sign or cosign the admissions agreement. No facility may accept or receive, as a condition of admission into the facility, the signature or cosignature of a responsible party for a Medi-Cal beneficiary.

(c) A facility may require, as a condition of admission, where a resident has an agent, that the resident's agent sign or cosign the admissions agreement and agree to distribute to the facility promptly when due, the ~~share of cost~~ long-term care patient

liability and any other charges not paid for by the Medi-Cal program ~~which~~ that the resident or ~~his or her~~ their agent has agreed to pay. The financial obligation of the agent shall be limited to the amount of the resident's funds received but not distributed to the facility. A new agent who did not sign or cosign the admissions agreement shall be held responsible to distribute funds in accordance with this section.

(d) When a resident on non-Medi-Cal status converts to Medi-Cal coverage, any security deposit paid to the facility by the resident or on the resident's behalf as a condition of admission to the facility shall be returned and the obligations and responsibilities of the resident or responsible party during the time period when the resident is covered by Medi-Cal shall be limited to the obligations and responsibilities provided for under the Medi-Cal program. In the event that the resident becomes ineligible for Medi-Cal coverage at any time subsequent to converting to Medi-Cal coverage, the resident and responsible party shall be bound by the terms of the original admission agreement, or any admission agreement in effect at the time the Medi-Cal coverage commenced.

(e) When a resident on non-Medi-Cal status converts to Medi-Cal coverage, the facility shall make a reasonable attempt to assist the resident in contacting the county to obtain an estimate of the resident's ~~share of cost.~~ long-term care patient liability.

(f) A resident and ~~his or her~~ their agent shall pay to the facility the ~~share of cost, for which he or she is~~ long-term care patient liability, for which they are responsible under the Medi-Cal program, unless otherwise exempted by law.

(g) If a resident or ~~his or her~~ their agent disputes the amount of ~~share of cost~~ the long-term care patient liability owed to a facility, the resident or agent may apply for a state hearing pursuant to Section 10950 for a determination of the amount ~~of share of cost~~ owed to the facility.

(h) Any agent who willfully violates the requirements of this section is guilty of a misdemeanor, and upon conviction thereof, shall be punished by a fine not to exceed two thousand five hundred dollars ($2,500) or by imprisonment in the county jail not to exceed 180 days, or both.

SEC. 27. Section 14132 of the Welfare and Institutions Code is amended to read:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) (1) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy, and occupational therapy, are covered subject to utilization controls.

(2) For a Medi-Cal fee-for-service beneficiary, emergency services and care that are necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition. This paragraph does not change the obligation of Medi-Cal managed care plans to provide emergency services and

care. For the purposes of this paragraph, "emergency services and care" and "emergency medical condition" have the same meanings as those terms are defined in Section 1317.1 of the Health and Safety Code.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities and any category of intermediate care facility for persons with developmental disabilities are covered subject to utilization controls.

(d) (1) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(2) Purchase of drugs used to treat erectile dysfunction or any off-label uses of those drugs are covered only to the extent that federal financial participation is available.

(3) (A) To the extent required by federal law, the purchase of outpatient prescribed drugs, for which the prescription is executed by a prescriber in written, nonelectronic form on or after April 1, 2008, is covered only when executed on a tamper resistant prescription form. The implementation of this paragraph shall conform to the guidance issued by the federal Centers for Medicare and Medicaid Services, but shall not conflict with state statutes on the characteristics of tamper resistant prescriptions for controlled substances, including Section 11162.1 of the Health and Safety Code. The department shall provide providers and beneficiaries with as much flexibility in implementing these rules as allowed by the federal government. The department shall notify and consult with appropriate stakeholders in implementing, interpreting, or making specific this paragraph.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instructions without taking regulatory action.

(4) (A) (i) For the purposes of this paragraph, nonlegend has the same meaning as defined in subdivision (a) of Section 14105.45.

(ii) Nonlegend acetaminophen-containing products, including children's acetaminophen-containing products, selected by the department are covered benefits.

(iii) Nonlegend cough and cold products selected by the department are covered benefits.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instruction without taking regulatory action.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs, and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and x-ray services are covered, subject to utilization controls. This subdivision does not require prior authorization for anesthesiologist services provided as part of an outpatient medical

procedure or for portable x-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses that are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children's Services program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative on July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) (1) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

(2) Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated is covered, subject to utilization controls. If there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

(3) Therapeutic shoes and inserts are covered when provided to a beneficiary with a diagnosis of diabetes, subject to utilization controls, to the extent that federal financial participation is available.

(*l*) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(n) Family planning services are covered, subject to utilization controls. However, for Medi-Cal managed care plans, utilization controls shall be subject to Section 1367.25 of the Health and Safety Code.

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) (1) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(2) Commencing 30 days after the effective date of the act that added this paragraph, and notwithstanding the number of days previously approved through a treatment authorization request, adult day health care is covered for a maximum of three days per week.

(3) As provided in accordance with paragraph (4), adult day health care is covered for a maximum of five days per week.

(4) As of the date that the director makes the declaration described in subdivision (g) of Section 14525.1, paragraph (2) shall become inoperative and paragraph (3) shall become operative.

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, and other prophylaxis treatment for children 17 years of age and under are covered.

(2) All dental hygiene services provided by a registered dental hygienist, registered dental hygienist in extended functions, and registered dental hygienist in alternative practice licensed pursuant to Sections 1753, 1917, 1918, and 1922 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental

hygienist, registered dental hygienist in extended functions, or registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under former Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of former Section 1482 of the article.

(2) A provider enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) (1) In-home medical care services are covered when medically appropriate and subject to utilization controls, for a beneficiary who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to a patient placed in a shared or congregate living arrangement, if a home setting is not medically appropriate or available to the beneficiary.

(2) As used in this subdivision, "in-home medical care service" includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

(3) As used in this subdivision, in-home medical care services include, but are not limited to:

(A) Level-of-care and cost-of-care evaluations.

(B) Expenses, directly attributable to home care activities, for materials.

(C) Physician fees for home visits.

(D) Expenses directly attributable to home care activities for shelter and modification to shelter.

(E) Expenses directly attributable to additional costs of special diets, including tube feeding.

(F) Medically related personal services.

(G) Home nursing education.

(H) Emergency maintenance repair.

(I) Home health agency personnel benefits that permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(J) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(K) Emergency and nonemergency medical transportation.

(L) Medical supplies.

(M) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(N) Utility use directly attributable to the requirements of home care activities that are in addition to normal utility use.

(O) Special drugs and medications.

(P) Home health agency supervision of visiting staff that is medically necessary, but not included in the home health agency rate.

(Q) Therapy services.

(R) Household appliances and household utensil costs directly attributable to home care activities.

(S) Modification of medical equipment for home use.

(T) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

(U) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

(4) A beneficiary receiving in-home medical care services is entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services are covered to the extent that federal financial participation is available for those services under the state plan or waivers granted in accordance with Section 1315 or 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1315 or 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) Hospice service that is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(x) When a claim for treatment provided to a beneficiary includes both services that are authorized and reimbursable under this chapter and services that are not reimbursable under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for a beneficiary with a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, who requires intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and that are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to a beneficiary in accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may, under this section, contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to an eligible beneficiary. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Program.

(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States Code, or a state plan amendment adopted in accordance with Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code, which was added to Section 1396a of Title 42 of the United States Code by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall use the standards and processes imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code. To the extent that federal financial participation is available, the program shall continue to conduct education, outreach, enrollment, service delivery, and evaluation services as specified under the waiver. The services shall be provided under the program only if the waiver and, when applicable, the successor state plan amendment are approved by the federal Centers for Medicare and Medicaid Services and only to the extent that federal financial participation is available for the services. This section does not prohibit the department

from seeking the Family PACT successor state plan amendment during the operation of the waiver.

(3) Solely for the purposes of the waiver or Family PACT successor state plan amendment and notwithstanding any other law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, without taking regulatory action, the provisions of the waiver after its approval by the federal Centers for Medicare and Medicaid Services and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) If the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) or the Family PACT successor state plan amendment is no longer cost effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no ~~share of cost,~~ spend down of excess income, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a ~~share of cost~~ spend down of excess income or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, "comprehensive clinical family planning services" means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that

threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at the next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

(F) Services, drugs, devices, and supplies deemed by the federal Centers for Medicare and Medicaid Services to be appropriate for inclusion in the program.

(G) (i) Home test kits for sexually transmitted diseases, including any laboratory costs of processing the kit, that are deemed medically necessary or appropriate and ordered directly by an enrolled Medi-Cal or Family PACT clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

(ii) For purposes of this subparagraph, “home test kit” means a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been

CLIA-waived, FDA-cleared or -approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

(iii) Reimbursement under this subparagraph shall be contingent upon the addition of codes specific to home test kits in the Current Procedural Terminology or Healthcare Common Procedure Coding System to comply with Health Insurance Portability and Accountability Act requirements. The home test kit shall be sent by the enrolled Family PACT provider to a Medi-Cal-enrolled laboratory with fee based on Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule.

(9) In order to maximize the availability of federal financial participation under this subdivision, the director shall have the discretion to implement the Family PACT successor state plan amendment retroactively to July 1, 2010.

(ab) (1) Purchase of prescribed enteral nutrition products is covered, subject to the Medi-Cal list of enteral nutrition products and utilization controls.

(2) Purchase of enteral nutrition products is limited to those products to be administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube. A beneficiary under the Early and Periodic Screening, Diagnostic, and Treatment Program shall be exempt from this paragraph.

(3) Notwithstanding paragraph (2), the department may deem an enteral nutrition product, not administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube, a benefit for patients with diagnoses, including, but not limited to, malabsorption and inborn errors of metabolism, if the product has been shown to be neither investigational nor experimental when used as part of a therapeutic regimen to prevent serious disability or death.

(4) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the amendments to this subdivision made by the act that added this paragraph by means of all-county letters, provider bulletins, or similar instructions, without taking regulatory action.

(5) The amendments made to this subdivision by the act that added this paragraph shall be implemented June 1, 2011, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.

(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.

(ad) (1) Nonmedical transportation is covered, subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services.

(2) (A) (i) Nonmedical transportation includes, at a minimum, round trip transportation for a beneficiary to obtain covered Medi-Cal services by passenger car, taxicab, or any other form of public or private conveyance, and mileage reimbursement when conveyance is in a private vehicle arranged by the beneficiary and not through a transportation broker, bus passes, taxi vouchers, or train tickets.

(ii) Nonmedical transportation does not include the transportation of a sick, injured, invalid, convalescent, infirm, or otherwise incapacitated beneficiary by ambulance, litter van, or wheelchair van licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations.

(B) Nonmedical transportation shall be provided for a beneficiary who can attest in a manner to be specified by the department that other currently available resources have been reasonably exhausted. For a beneficiary enrolled in a managed care plan, nonmedical transportation shall be provided by the beneficiary's managed care plan. For a Medi-Cal fee-for-service beneficiary, the department shall provide nonmedical transportation when those services are not available to the beneficiary under Sections 14132.44 and 14132.47.

(3) Nonmedical transportation shall be provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the beneficiary and consistent with applicable state and federal disability rights laws.

(4) It is the intent of the Legislature in enacting this subdivision to affirm the requirement under Section 431.53 of Title 42 of the Code of Federal Regulations, in which the department is required to provide necessary transportation, including nonmedical transportation, for recipients to and from covered services. This subdivision shall not be interpreted to add a new benefit to the Medi-Cal program.

(5) The department shall seek any federal approvals that may be required to implement this subdivision, including, but not limited to, approval of revisions to the existing state plan that the department determines are necessary to implement this subdivision.

(6) This subdivision shall be implemented only to the extent that federal financial participation is available and not otherwise jeopardized and any necessary federal approvals have been obtained.

(7) Prior to the effective date of any necessary federal approvals, nonmedical transportation was not a Medi-Cal managed care benefit with the exception of when provided as an Early and Periodic Screening, Diagnostic, and Treatment service.

(8) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. By July 1, 2018, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing January 1, 2018, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(9) This subdivision shall not be implemented until July 1, 2017.

(ae) (1) No sooner than January 1, 2022, Rapid Whole Genome Sequencing, including individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing, is a covered benefit for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit.

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted.

(3) This subdivision shall be implemented only to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized.

(af) (1) Home test kits for sexually transmitted diseases that are deemed medically necessary or appropriate and ordered directly by an enrolled Medi-Cal clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

(2) For purposes of this subdivision, "home test kit" means a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been CLIA-waived, FDA-cleared or -approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

(3) Reimbursement under this subparagraph shall be contingent upon the addition of codes specific to home test kits in the Current Procedural Terminology or Healthcare Common Procedure Coding System to comply with Health Insurance Portability and Accountability Act requirements. The home test kit shall be sent by the enrolled Medi-Cal provider to a Medi-Cal-enrolled laboratory with fee based on Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule.

(4) This subdivision shall be implemented only to the extent that federal financial participation is available and not otherwise jeopardized, and any necessary federal approvals have been obtained.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking any further regulatory action.

(ag) (1) Violence prevention services are covered, subject to medical necessity and utilization controls.

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted.

(3) This subdivision shall be implemented only to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized.

(4) The department shall post on its internet website the date upon which violence prevention services may be provided and billed pursuant to this subdivision.

(5) "Violence prevention services" means evidence-based, trauma-informed, and culturally responsive preventive services provided to reduce the incidence of violent injury or reinjury, trauma, and related harms and promote trauma recovery, stabilization, and improved health outcomes.

SEC. 28. Section 14132.56 of the Welfare and Institutions Code is amended to read:

14132.56. (a) (1) Only to the extent required by the federal government and effective no sooner than required by the federal government, behavioral health treatment (BHT) shall be a covered Medi-Cal service for individuals under 21 years of age.

(2) It is the intent of the Legislature that, to the extent the federal government requires BHT to be a covered Medi-Cal service, the department shall seek statutory authority to implement this new benefit in Medi-Cal.

(3) For purposes of this section, "behavioral health treatment" or "BHT" means professional services and treatment programs, including applied behavior analysis (ABA) and evidence-based intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and are administered by the department as described in the approved state plan.

(b) The department shall implement, or continue to implement, this section only after all of the following occurs or has occurred:

(1) The department receives all necessary federal approvals to obtain federal funds for the service.

(2) The department seeks an appropriation that would provide the necessary state funding estimated to be required for the applicable fiscal year.

(3) The department consults with stakeholders.

(c) The department shall develop and define eligibility criteria, provider participation criteria, utilization controls, and delivery system structure for services under this section, subject to limitations allowable under federal law, in consultation with stakeholders.

(d) (1) The department, commencing on the effective date of the act that added this subdivision until March 31, 2017, inclusive, may make available to individuals described in paragraph (2) contracted services to assist those individuals with health insurance enrollment, without regard to whether federal funds are available for the contracted services.

(2) The contracted services described in paragraph (1) may be provided only to an individual under 21 years of age whom the department identifies as no longer eligible for Medi-Cal solely due to the transition of BHT coverage from the waiver program under Section 1915(c) of the federal Social Security Act to the Medi-Cal state plan in accordance with this section and who meets all of the following criteria:

(A) ~~He or she was~~ They were enrolled in the home and community-based services waiver for persons with developmental disabilities under Section 1915(c) of the Social Security Act as of January 31, 2016.

(B) ~~He or she was~~ They were deemed to be institutionalized in order to establish eligibility under the terms of the waiver.

(C) ~~He or she has~~ They have not been found eligible under any other federally funded Medi-Cal criteria without a ~~share of cost.~~ spend down of excess income.

(D) ~~He or she had~~ They have received a BHT service from a regional center for persons with developmental disabilities as provided in Chapter 5 (commencing with Section 4620) of Division 4.5.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions

until regulations are adopted. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Notwithstanding Section 10231.5 of the Government Code, beginning six months after the effective date of this section, the department shall provide semiannual status reports to the Legislature, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(f) For the purposes of implementing this section, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including contracts for the purpose of obtaining subject matter expertise or other technical assistance. Contracts may be statewide or on a more limited geographic basis. Contracts entered into or amended under this subdivision shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(g) The department may seek approval of any necessary state plan amendments or waivers to implement this section. The department shall make any state plan amendments or waiver requests public at least 30 days prior to submitting to the federal Centers for Medicare and Medicaid Services, and the department shall work with stakeholders to address the public comments in the state plan amendment or waiver request.

(h) This section shall be implemented only to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 29. Section 14132.95 of the Welfare and Institutions Code is amended to read:

14132.95. (a) Personal care services, when provided to a categorically needy person as defined in Section 14050.1 is a covered benefit to the extent federal financial participation is available if these services are:

(1) Provided in the beneficiary's home and other locations as may be authorized by the director subject to federal approval.

(2) Authorized by county social services staff in accordance with a plan of treatment.

(3) Provided by a qualified person.

(4) Provided to a beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services described in this section.

(b) The department shall seek federal approval of a state plan amendment necessary to include personal care as a Medicaid service pursuant to subdivision (f) of Section 440.170 of Title 42 of the Code of Federal Regulations. For any persons who meet the criteria specified in subdivision (a) or (p), but for whom federal financial participation is not available for a service or services under this section, eligibility for the service or services shall be determined according to the waiver authorized pursuant to Section 14132.951. If federal financial participation for the service or services is not available under this section or Section 14132.951, eligibility for the service or

services shall be determined pursuant to Article 7 (commencing with Section 12300) of Chapter 3.

(c) Subdivision (a) shall not be implemented unless the department has obtained federal approval of the state plan amendment described in subdivision (b), and the Department of Finance has determined, and has informed the department in writing, that the implementation of this section will not result in additional costs to the state relative to state appropriation for in-home supportive services under Article 7 (commencing with Section 12300) of Chapter 3, in the 1992–93 fiscal year.

(d) (1) For purposes of this section, personal care services shall mean all of the following:

(A) Assistance with ambulation.

(B) Bathing, oral hygiene and grooming.

(C) Dressing.

(D) Care and assistance with prosthetic devices.

(E) Bowel, bladder, and menstrual care.

(F) Skin care.

(G) Repositioning, range of motion exercises, and transfers.

(H) Feeding and assurance of adequate fluid intake.

(I) Respiration.

(J) Paramedical services.

(K) Assistance with self-administration of medications.

(2) Ancillary services including meal preparation and cleanup, routine laundry, shopping for food and other necessities, and domestic services may also be provided as long as these ancillary services are subordinate to personal care services. Ancillary services may not be provided separately from the basic personal care services.

(e) (1) (A) After consulting with the State Department of Social Services, the department shall adopt emergency regulations to establish the amount, scope, and duration of personal care services available to persons described in subdivision (a) in the fiscal year whenever the department determines that General Fund expenditures for personal care services provided under this section and expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3, are expected to exceed the General Fund appropriation and the federal appropriation under Title XX of the federal Social Security Act provided for the 1992–93 fiscal year pursuant to Article 7 (commencing with Section 12300) of Chapter 3, as it read on June 30, 1992, as adjusted for caseload growth or as increased in the Budget Act or appropriated by statute. At least 30 days prior to filing these regulations with the Secretary of State, the department shall give notice of the expected content of these regulations to the fiscal committees of both houses of the Legislature.

(B) In establishing the amount, scope, and duration of personal care services, the department shall ensure that General Fund expenditures for personal care services provided for under this section and expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3, do not exceed the General Fund appropriation and the federal appropriation under Title XX of the federal Social Security Act provided for the 1992–93 fiscal year pursuant to Article 7

(commencing with Section 12300) of Chapter 3, as it read on June 30, 1992, as adjusted for caseload growth or as increased in the Budget Act or appropriated by statute.

(C) For purposes of this subdivision, "caseload growth" means an adjustment factor determined by the department based on (1) growth in the number of persons eligible for benefits under Chapter 3 (commencing with Section 12000) on the basis of their disability, (2) the average increase in the number of hours in the program established pursuant to Article 7 (commencing with Section 12300) of Chapter 3 in the 1988–89 to 1992–93 fiscal years, inclusive, due to the level of impairment, and (3) any increase in program costs that is required by an increase in the mandatory minimum wage.

(2) In establishing the amount, scope, and duration of personal care services pursuant to this subdivision, the department may define and take into account, among other things:

(A) The extent to which the particular personal care services are essential or nonessential.

(B) Standards establishing the medical necessity of the services to be provided.

(C) Utilization controls.

(D) A minimum number of hours of personal care services that must first be assessed as needed as a condition of receiving personal care services pursuant to this section.

The level of personal care services shall be established so as to avoid, to the extent feasible within budgetary constraints, medical out-of-home placements.

(3) To the extent that General Fund expenditures for services provided under this section and expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3 in the 1992–93 fiscal year, adjusted for caseload growth, exceed General Fund expenditures for services provided under this section and expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3 in any fiscal year, the excess of these funds shall be expended for any purpose as directed in the Budget Act or as otherwise statutorily disbursed by the Legislature.

(f) Services pursuant to this section shall be rendered, under the administrative direction of the State Department of Social Services, in the manner authorized in Article 7 (commencing with Section 12300) of Chapter 3, for the In-Home Supportive Services program. A provider of personal care services shall be qualified to provide the service and shall be a person other than a member of the family. For purposes of this section, a family member means a parent of a minor child or a spouse.

(g) The maximum number of hours available under the In-Home Supportive Services program pursuant to Article 7 (commencing with Section 12300) of Chapter 3, Section 14132.951, and this section, combined, shall be 283 hours per month.

(h) Personal care services shall not be provided to residents of facilities licensed by the department, and shall not be provided to residents of a community care facility or a residential care facility for the elderly licensed by the Community Care Licensing Division of the State Department of Social Services.

(i) Subject to any limitations that may be imposed pursuant to subdivision (e), determination of need and authorization for services shall be performed in accordance with Article 7 (commencing with Section 12300) of Chapter 3.

(j) (1) To the extent permitted by federal law, reimbursement rates for personal care services shall be equal to the rates in each county for the same mode of services in the In-Home Supportive Services program pursuant to Article 7 (commencing with Section 12300) of Chapter 3, plus any increase provided in the annual Budget Act for personal care services rates or included in a county budget pursuant to paragraph (2).

(2) (A) The department shall establish a provider reimbursement rate methodology to determine payment rates for the individual provider mode of service that does all of the following:

(i) Is consistent with the functions and duties of entities created pursuant to Section 12301.6.

(ii) Makes any additional expenditure of state general funds subject to appropriation in the annual Budget Act.

(iii) Permits county-only funds to draw down federal financial participation consistent with federal law.

(B) This ratesetting method shall be in effect in time for any rate increases to be included in the annual Budget Act.

(C) The department may, in establishing the ratesetting method required by subparagraph (A), do both of the following:

(i) Deem the market rate for like work in each county, as determined by the Employment Development Department, to be the cap for increases in payment rates for individual practitioner services.

(ii) Provide for consideration of county input concerning the rate necessary to ensure access to services in that county.

(D) If an increase in individual practitioner rates is included in the annual Budget Act, the state-county sharing ratio shall be as established in Section 12306. If the annual Budget Act does not include an increase in individual practitioner rates, a county may use county-only funds to meet federal financial participation requirements consistent with federal law.

(3) (A) By November 1, 1993, the department shall submit a state plan amendment to the federal Health Care Financing Administration to implement this subdivision. To the extent that any element or requirement of this subdivision is not approved, the department shall submit a request to the federal Health Care Financing Administration for any waivers as would be necessary to implement this subdivision.

(B) The provider reimbursement ratesetting methodology authorized by the amendments to this subdivision in the 1993–94 Regular Session of the Legislature shall not be operative until all necessary federal approvals have been obtained.

(k) (1) The State Department of Social Services shall, by September 1, 1993, notify the following persons that they are eligible to participate in the personal care services program:

(A) Persons eligible for services pursuant to the Pickle Amendment, as adopted October 28, 1976.

(B) Persons eligible for services pursuant to subsection (c) of Section 1383c of Title 42 of the United States Code.

(2) The State Department of Social Services shall, by September 1, 1993, notify persons to whom paragraph (1) applies and who receive advance payment for in-home supportive services that they will qualify for services under this section without a ~~share of cost~~ spend down of excess income if they elect to accept payment for services on an arrears rather than an advance payment basis.

(*l*) An individual who is eligible for services subject to the maximum amount specified in subdivision (b) of Section 12303.4 shall be given the option of hiring ~~his or her~~ their own provider.

(m) The county welfare department shall inform in writing any individual who is potentially eligible for services under this section of ~~his or her~~ their right to the services.

(n) It is the intent of the Legislature that this entire section be an inseparable whole and that no part of it be severable. If any portion of this section is found to be invalid, as determined by a final judgment of a court of competent jurisdiction, this section shall become inoperative.

(o) Paragraphs (2) and (3) of subdivision (a) shall be implemented so as to conform to federal law authorizing their implementation.

(p) (1) Personal care services shall be provided as a covered benefit to a medically needy aged, blind, or disabled person, as defined in subdivision (a) of Section 14051, to the same extent and under the same requirements as they are provided under subdivision (a) of this section to a categorically needy, aged, blind, or disabled person, as defined in subdivision (a) of Section 14050.1, and to the extent that federal financial participation is available.

(2) The department shall seek federal approval of a state plan amendment necessary to include personal care services described in paragraph (1) as a Medicaid service pursuant to subdivision (f) of Section 440.170 of Title 42 of the Code of Federal Regulations.

(3) In the event that the Department of Finance determines that expenditures of both General Fund moneys for personal care services provided under this subdivision to medically needy aged, blind, or disabled persons together with expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for all aged, blind, and disabled persons receiving in-home supportive services pursuant to Article 7 (commencing with Section 12300) of Chapter 3, in the 2000–01 fiscal year or in any subsequent fiscal year, are expected to exceed the General Fund appropriation and the federal appropriation received under Title XX of the federal Social Security Act for expenditures for all aged, blind, and disabled persons receiving in-home supportive services provided in the 1999–2000 fiscal year pursuant to Article 7 (commencing with Section 12300) of Chapter 3, as it read on June 30, 1998, as adjusted for caseload growth or as changed in the Budget Act or by statute or regulation, then this subdivision shall cease to be operative on the first day of the month that begins after the expiration of a period of 30 days subsequent to a notification in writing by the Director of the Department of Finance to the chairperson of the committee in each house that considers appropriations, the chairpersons of the committees and the appropriate subcommittees in each house that consider the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(4) Solely for purposes of paragraph (3), caseload growth means an adjustment factor determined by the department based on:

(A) Growth in the number of persons eligible for benefits under Chapter 3 (commencing with Section 12000) on the basis of their disability.

(B) The average increase in the number of hours in the program established pursuant to Article 7 (commencing with Section 12300) of Chapter 3 in the 1994–95 to 1998–99 fiscal years, inclusive, due to the level of impairment.

(C) Any increase in program cost that is required by an increase in hourly costs pursuant to the Budget Act or statute.

(5) In the event of a final judicial determination by any court of appellate jurisdiction or a final determination by the Administrator of the federal Centers for Medicare and Medicaid Services that personal care services must be provided to any medically needy person who is not aged, blind, or disabled, then this subdivision shall cease to be operative on the first day of the first month that begins after the expiration of a period of 30 days subsequent to a notification in writing by the Director of Finance to the chairperson of the committee in each house that considers appropriations, the chairpersons of the committees and the appropriate subcommittees in each house that consider the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(6) If this subdivision ceases to be operative, all aged, blind, and disabled persons who would have been eligible to receive services under this section shall be immediately eligible for services under the IHSS Plus waiver authorized pursuant to Section 14132.951, if otherwise eligible, upon this section becoming inoperative. If this section becomes inoperative and a person is ineligible for the IHSS Plus waiver, then eligibility shall be determined under the In-Home Supportive Services program pursuant to Article 7 (commencing with Section 12300) of Chapter 3.

SEC. 30. Section 14132.99 of the Welfare and Institutions Code is amended to read:

14132.99. (a) For the purposes of this section, "facility residents" means individuals who are currently residing in a nursing facility and whose care is paid for by Medi-Cal either with or without a ~~share of cost.~~ long-term care patient liability. The term "facility residents" also includes individuals who are hospitalized and who are or will be waiting for transfer to a nursing facility.

(b) For those patients who are in acute care hospitals and who are pending placement in a nursing facility, the department shall expedite the processing of waiver applications in order to divert hospital discharges from nursing facilities into the community.

(c) The Nursing Facility/Acute Hospital Transition and Diversion Waiver shall include the following services:

(1) One-time community transition services as defined and allowed by the federal Centers for Medicare and Medicaid Services, including, but not limited to, security deposits that are required to obtain a lease on an apartment or home, essential furnishings, and moving expenses required to occupy and use a community domicile, set-up fees, or deposits for utility or service access, including, but not limited to, telephone, electricity, and heating, and health and safety assurances, including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy. These costs shall not exceed five thousand dollars ($5,000).

(2) Habilitation services, as defined in Section 1915(c)(5) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)(5)), and in attachment 3-d to the July 25, 2003,

State Medicaid Directors Letter re Olmstead Update No. 3, to mean services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home- and community-based settings.

(d) (1) (A) Notwithstanding paragraphs (1) and (2) of subdivision (d) of Section 12300.4, the department shall grant an exemption, as described in paragraph (2), to a provider of an applicant or participant of the Nursing Facility/Acute Hospital Transition and Diversion Waiver or the In-Home Operations Waiver, or their successors, who was enrolled in either waiver on January 31, 2016, and whose medical or behavioral needs require that the services to the applicant or participant be provided by the requested provider, if any of the following circumstances exists:

(i) The provider lives in the same home as the waiver applicant or participant, even if the provider is not a family member.

(ii) The provider currently provides care to the waiver participant, and has done so for two or more years continuously.

(iii) The waiver applicant or participant is unable to find a local caregiver who speaks the same language as the applicant or participant, resulting in the applicant or participant being unable to direct ~~his or her~~ their own care.

(B) For a waiver participant who enrolls in either waiver after January 31, 2016, the department shall grant a provider an exemption from the workweek requirements described in paragraphs (1) and (2) of subdivision (d) of Section 12300.4 on a case-by-case basis pursuant to paragraph (5).

(2) A provider of in-home supportive services or waiver personal care services who is granted an exemption pursuant to paragraph (1) may work up to a total of 12 hours per day, and up to 360 hours per month combined for the in-home supportive services and waiver personal care services that ~~he or she provides,~~ they provide, not to exceed each waiver participant's monthly authorized hours.

(3) On a one-time basis upon implementation of this paragraph, the department shall mail an informational notice and an exemption request form to all providers who may be eligible for an exemption pursuant to this subdivision and to the waiver participants to whom the providers provide services.

(4) At the time of initial application, and at least annually, the department shall inform all waiver applicants or participants whose providers may be eligible for an exemption pursuant to this subdivision and their providers about the exemptions and the application process.

(5) (A) The department shall review the requests for consideration for an exemption described in subparagraph (B) of paragraph (1) pursuant to a process developed by the department with input from stakeholders. The department shall consider whether the waiver applicant or participant meets the criteria described in subparagraph (A) of paragraph (1) in making its determination.

(B) Within 30 days of receiving an application for an exemption described in subparagraph (B) of paragraph (1) from a provider and from a waiver applicant or participant on behalf of a provider, the department shall mail a written notification letter to the provider and the waiver applicant or participant for whom the provider provides services of its approval or denial of the exemption. If the department denies the exemption, the department shall also explain in the notification letter the reason for the denial. The department shall use a standardized notification letter, developed

by the department in consultation with stakeholders, for purposes of providing the notification letter that is required by this subparagraph.

(6) The department shall record the number of requests for exemptions that are received and the number of requests approved or denied. These numbers shall be posted no later than every three months on the department's ~~Internet Web site.~~ internet website.

(e) The department shall implement this section only to the extent it can demonstrate fiscal neutrality within the overall department budget, and federal fiscal neutrality as required under the terms of the federal waiver, and only if the department has obtained the necessary approvals and receives federal financial participation from the federal Centers for Medicare and Medicaid Services.

SEC. 31. Section 14148.5 of the Welfare and Institutions Code is amended to read:

14148.5. (a) State funded perinatal services shall be provided under the Medi-Cal program to pregnant women and state funded medical services to infants up to one year of age in families with incomes above 185 percent, but not more than 208 percent, of the federal poverty level, in the same manner that these services are being provided to the Medi-Cal population, including eligibility requirements and integration of eligibility determinations and payment of claims. When determining eligibility under this section, an applicant's or beneficiary's income and resources shall be determined, counted, and valued in accordance with the methodology set forth in Section 14005.64.

(b) Services provided under this section shall not be subject to any ~~share-of-cost~~ spend down of excess income requirements.

(c) (1) The department, in implementing the Medi-Cal program and public health programs, in coordination with the Managed Risk Medical Insurance Board's Access for Infants and Mothers component, may provide for outreach activities in order to enhance participation and access to perinatal services. Funding received pursuant to the federal provisions shall be used to expand perinatal outreach activities. These outreach activities shall be implemented if funding is provided for this purpose by an appropriation in the annual Budget Act or other statute.

(2) Those outreach activities authorized by paragraph (1) shall be targeted toward both Medi-Cal and non-Medi-Cal eligible high risk or uninsured pregnant women and infants. Outreach activities may include, but not be limited to, all of the following:

(A) Education of the targeted women on the availability and importance of early prenatal care and referral to Medi-Cal and other programs.

(B) Information provided through toll-free telephone numbers.

(C) Recruitment and retention of perinatal providers.

(d) Notwithstanding any other law, contracts required to implement the provisions of this section shall be exempt from the approval of the Director of General Services and from the provisions of the Public Contract Code.

SEC. 32. Section 14154.5 of the Welfare and Institutions Code is amended to read:

14154.5. (a) Each county shall work, on a routine basis, any error alert from the department's Medi-Cal Eligibility Data System (MEDS). Any alert that affects eligibility or the ~~share of cost~~ spend down of excess income that is received by the 10th working day of the month shall be processed in time for the change to be effective the beginning of the following month. Any alert that affects eligibility or the ~~share of cost~~ spend down of excess income that is received after the 10th working day of the

month shall be processed in time for the change to be effective the beginning of the month after the following month. The department shall consult with the County Welfare Directors Association to define those alerts that affect eligibility or the ~~share of cost.~~ spend down of excess income.

(b) The county shall submit reconciliation files of its Medi-Cal eligible population to the department every three months, based upon a schedule determined by the department and in a format prescribed by the department, to identify any discrepancies between eligibility files in the county records and eligibility as reflected in MEDS. Counties shall be notified of any changes to the standard format for submitting reconciliation files sufficiently in advance to allow for budgeting, scheduling, development, testing, and implementation of any required change in county automated eligibility systems.

(c) For those records that are on the county's files, but not on MEDS, the county shall receive worker alerts from the department that identify these cases, and the county shall fix any data discrepancies. Any worker alert received by the 10th working day of the month shall be processed in time for the change to be effective the beginning of the following month. Any worker alert received after the 10th working day of the month shall be processed in time for the change to be effective the beginning of the month after the following month.

(d) In regard to any record that is on MEDS but not on the county's file, the county shall either correct the county record or MEDS, whichever is appropriate, within the same timeframes specified in subdivision (c).

(e) The department shall terminate a MEDS-eligible record if the person is not eligible on the county's file when there has been no eligibility update on the MEDS record for six months.

(f) (1) If the department finds that a county is not performing all of the following activities, the county shall, within 60 days, submit a corrective action plan to the department for approval:

(A) Conducting reconciliations as required in subdivision (b).

(B) Processing 95 percent of worker alerts referred to in subdivisions (c) and (d), within the timeframes specified.

(C) Processing 90 percent of the error alerts referred to in subdivision (a) that affect eligibility or the ~~share of cost,~~ spend down of excess income, within the timeframes specified.

(2) The corrective action plan shall, at a minimum, include steps that the county shall take to improve its performance on the requirements with which the county is out of compliance. The plan shall establish interim benchmarks for improvement that shall be expected to be met by the county in order to avoid sanctions.

(g) (1) If the county does not meet the interim benchmarks for improvement standards, the department may, in its sole discretion, reduce the allocation of funds to that county in the following year by 2 percent. Any funds so reduced may be restored by the department if, in the determination of the department, sufficient improvement has been made by the county in meeting the performance standards during the year for which the funds were reduced.

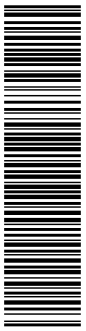
(2) No reduction of the allocation of funds to a county shall be imposed pursuant to this subdivision for failure to meet performance standards during any period of time in which the cost-of-doing-business increase is suspended.

(h) The department, in consultation with the County Welfare Directors Association, shall investigate features that could be installed in MEDS to reduce the number of alerts and streamline the reconciliation process.

(i) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, provider bulletins, or similar instructions. Thereafter, the department may adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.
as introduced, _____.
General Subject: Medi-Cal: share of cost.



Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, certain medically needy persons, including those in long-term care, with higher incomes qualify for Medi-Cal with a share of cost, if they meet specified criteria. Under existing law, the term "share of cost" means the amount of the costs of health care that a specified person or family is required to incur prior to being certified by the department.

This bill would instead apply the term "spend down of excess income" to the above-described definition for "share of cost" for medically needy persons. The bill would change references from "share of cost" to "long-term care patient liability," in the context of those persons entering or in long-term care and define that term as the result of the "post-eligibility treatment of income" calculation and the amount of medical expenses the person in long-term care or an institutionalized spouse is required to incur or expected to incur. The bill would define the term "post-eligibility treatment of income" as the determination of long-term care patient liability for each month the person is in long-term care or as an institutionalized spouse, as specified.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.